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HOUSING AND RELATED SERVICES FOR EXCEPTIONAL PERSONS: A Source Book

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A SOURCE BOOK

by

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PROLOG

Few would consider our existing domestic programs adequate. A major problem is the determination and achievement of an equitable distribution of resources and responsibilities - among residents, among units of government. While poverty has yet to receive an effective and appropriate response, Americans are becoming increasingly disillusioned with the quality of the goods and services currently in the market. Rich and poor alike are troubled by pollution and inadequate public services. Many seek services which are not available at any price.

This dilemma is especially characteristic of our possibly thirty million exceptional persons. The term exceptional is used in this report to refer to that group of persons whose wealth, education and abilities are subordinate to their stigma or disability in intercourse with the balance of society. Used broadly, the term incorporates the aged, the physically handicapped, the mentally ill and retarded and inmates of prisons and other institutions. The term exceptional persons will be used here to refer specifically to the aged and physically handicapped and mentally retarded adults.

Some exceptional persons suffer greater indignities than others: the executive whose productive career is arbitrarily terminated by compulsory retirement; the elderly widow committed to a state mental hospital because there

exists neither a suitable public institution nor private housing and care which she can afford; and the disabled accountant who cannot return to work because of architectural barriers preventing access to those in wheelchairs. In extreme cases an exceptional individual is perceived as a non-person, an inanimate object. One discrete disability, e.g., paralysis, is often taken as evidence of total disability or absence of value. Push someone's wheelchair in public and you find yourself perceived as that person's custodian, e.g., "Would he like a drink?" At best, an exceptional person experiences disabilities beyond those of his specific affliction. The aged are too quickly assumed to be senile; a paraplegic woman is often perceived as being asexual. In short, the problem of the exceptional person involves both inadequate services and the violation of basic human rights.

While the problem of the exceptional person is largely a social phenomenon, it does have a very definite physical locus. His situation is quite analogous to that of a resident of a public housing project who is subjected to a policy of aggregation, segregation and stigmatization. Subsidized housing, the proposed housing allowance and, better yet, a guaranteed annual income reflect a more sensitive and competent approach to the problem of housing the poor. Such an approach addresses the immediate problem, e.g., housing, while being less inclined to impose secondary disabilities: restricted

mobility and freedom of choice, stigma, deteriorating services, etc. The increased use of market mechanisms and decreased tendencies toward bureaucratic intervention has - at least in theory - made this approach popular with liberals and conservatives alike.

Public policy regarding the care of the mentally ill and retarded has similarly changed to favor decentralized, community based services and is justified both administratively and therapeutically. Public policy regarding service for other exceptional persons is gradually, but persistently, changing from one of segregation and isolation to one promoting integration and normalization. The exceptional individual is to be assisted only in his specific areas of need; his activity in all other matters is to be left uninterrupted. This approach maximizes the use of outpatient and home health services. Where public financial assistance is necessary, it is in the form of vendor payments or allowances as opposed to commitment to a public institution.

Community bases support services are being developed. What is also required - and is emerging less rapidly, however - is housing and homemaking assistance tailored to the needs of the exceptional person. This presents both a new opportunity and a new responsibility for the private sector. Voluntary and proprietary organizations can and must become actively involved if exceptional persons are ever to be integrated into the community.

The integration of exceptional persons thus involves an interface among the social services and income maintenance systems and the health and housing industries. The purpose of this paper is to briefly examine this interface and suggest sources for more intensive study. Reflected here are the following assumptions and observations:

1. A great many persons are placed in facilities offering an intensity of care greater than what is actually required with a resulting waste of public and/or private funds and often negative therapeutic consequences. The scarcity and rigidity of most existing facilities fail to provide the needed services at an acceptable price. Many more facilities offering more diversified types and intensities of care are urgently needed.

2. The scarcity of these facilities has produced a situation in which government officials are understandably reluctant to properly enforce quality standards. If they revoke licenses, they will only decrease the supply of badly needed services. Nursing homes and similar facilities in many areas enjoy a captive market with little incentive to improve quality in the absence of meaningful competition.

3. While community based programs for exceptional persons are justified on purely therapeutic grounds, they become imperative given the passivity and fiscal restraint characteristic of current federal policy. We shall demonstrate that such programs can be operated at, or possibly below,

the cost of current practices.

4. The normalization approach, by increasing the number of actors, maximizes individual choice and opportunities for innovation.

5. Facilities for exceptional persons are an excellent example of an instance in which supply generates demand. Traditional marketing studies are biased by decisions made under conditions of imperfect knowledge of alternatives. Thus, decisions made on the basis of such studies perpetuate traditional mechanisms.

6. Neither local governments nor charitable institutions, hard pressed by inflation and sunken capital investments, are likely to venture into such an unchartered area to any significant extent.

7. Private investors will also be discouraged by the absence of documented feasibility and the fear of future governmental restrictions. The private sector does, however, offer the best hope for a rapid and successful implementation of such services. A recent unpublished study by Arthur D. Little, Inc. reportedly claims that residential programs for exceptional persons represent a highly profitable and virgin industry. Beneficial participation of the private sector could be accelerated if the federal government made some widely publicized demonstration grants, established national minimum performance criteria and liberalized the Medicaid and Medicare regulations to allow greater consumer choice.

Programs for exceptional persons could thus be greatly expanded primarily through administrative changes as opposed to greater public fiscal expenditure.

8. While these initital services would doubtless be priced too high for all but the wealthy, they would profoundly affect the public welfare in the (not very) long run. First, the initial services would demonstrate the economic feasibility of the concept and speed the evolution of improved systems. Secondly, other investors would respond to this demonstrated success, possibly forcing down prices and increasing the alternatives available to the consumer. Third, nonprofit institutions would be able to pattern programs after successful proprietary ventures, operating, perhaps, at the break-even point. Fourth, the new life style generated by the upper and middle classes in private facilities would probably filter down very rapidly throughout the entire population stimulating public acceptance of the approach and demands for similar, publically underwritten systems for the less fortunate. Acceptable care for some classes of exceptional persons does not exist even for the wealthy; it would thus be difficult to win public acceptance of heavy government investment in such areas until these services become integrated into the "American Way of Life."

9. Buildings designed to facilitate access by exceptional persons cost little, if anything, more than conventional construction with little, if any, sacrifice of aesthetic

qualities. More significantly, programs and facilities designed for exceptional persons benefit normal persons as well.

10. Nowhere is the potential for fully integrated communities greater than in the increasingly popular planned unit development (P.U.D.). This form of real estate development with its proximity of office, commerical and residential uses has been proven to be an attractive alternative to suburban sprawl and strip development. It is totally feasible that an entire P.U.D. could be designed to allow complete access to someone in a wheelchair. Families containing an exceptional person could continue to function without drastically altering their life style. The P.U.D. offers economies of scale such that the needed ancillary services (catered meals, home health and personal aides, minibus transportation and homemaker services) could be provided - perhaps through cooperatives - at considerable savings to the residents. Most important, such environments would allow exceptional persons and their families to live lives as nearly normal as their disabilities will allow.

11. The adoption of a conscious policy of decentralization of services and a heavy reliance on the private sector is not without some grave dangers. While certain regulations must be made more flexible to allow a continuum of services, greater standardization of payment schedules and building and health codes is essential. Quality control efforts should be

streamlined and strengthened. The success of such an approach also depends significantly upon the emergence of a highly organized and vocal consumer movement.

12. Properly implemented and administered, the disaggregated approach would greatly improve the quality of care received by exceptional persons and actually minimize their victimization by health care monopolies. A greater reliance on allowances and a marked expansion in the number and type of services available would increase the power of the consumer and accelerate his integration into the "normal" community. The situation of the exceptional person would change markedly from that in which he was a patient or inmate whose dependence is exaggerated to one in which he is a consumer whose independence is reinforced. Properly done, millions of Americans would be refranchised as human beings.

It has been stated that there is a need for a greater diversity in the housing and service choices offered exceptional persons. This diversity can best be explained through use of the matrix presented in table 3. The horizontal rows relate to the degree of dependency characteristic of the residents of various institution. As the degree of dependency increases, so also does the cost of acceptable care. The three vertical columns relate to the three classes of exceptional persons considered in this report and to the specific types of care required by each. The aged require general

medical services to a greater degree than the normal population; the physically handicapped need physical and vocational therapy and rehabilitative medical attention; the mentally retarded primarily require training and intensive custodial care.

The term independent housing is used to describe conventional dwelling units in which the occupants are free from external supervision except in the form of occasional counceling and medical care. The locus of power rests entirely with the resident; if assistance is required, he hires it as would any normal consumer. Independent housing can be integrated into the normal community or segregated into clusters of exceptional persons, e.g., H.U.D. insured high rise apartments for the elderly, retirement communities in Arizona, California and Florida.

Semi-independent housing describes a situation in which care is provided on a more structured basis. Private dwelling units, often efficiency and one bedroom apartments, are clustered in close proximity to a central service core. One monthly fee provides for the rental of the dwelling, a specified number of catered and/or cafeteria meals, and minimal housekeeping services. Semi-independent housing is most economically feasible when it is built adjacent to a boarding home or nursing facility and placed under the same management. This arrangement provides the economies of scale that adequate care can be offered at reasonable rates.

Boarding homes represent a marked shift from the aura of normalcy afforded by conventional housing. While being the least "institutional" of all congregate living arrangements, they are institutions none the less. Boarding homes are the most difficult to identify and do not appear to have an organized constituency. They bear many titles: rest homes, retirement hotels, homes for senior citizens, private proprietary homes for adults. Their major similarity is that they do not provide medical care. Boarding homes are the most intensive of the facilities for exceptional persons generally not under the close supervision of state and local health authorities and the U. S. Department of Health, Education and Welfare. While such facilities have traditionally been owned by small entrepreneurs and charitable institutions, there is a growing trend toward participation by more sophisticated, proprietary corporations.

Intermediate Care Facilities represent a transition between the personal care provided in boarding homes and the more rigorous medical attention available in nursing homes. The regulations under which they operate vary considerably from state to state. Generally such facilities offer a low intensity of health care administered primarily by licensed practical nurses. The majority of the patients are ambulatory; the locus of control, however, is held by the facility's administration.

Nursing homes are institutions which are capable of providing medical attention to those convalescing from surgery or acute illness and those with chronic conditions. Medical care is administered by registered nurses under the direction of either a resident medical director or the patient's personal physician. While the quality and intensity of care vary among various nursing homes, regulations enforced by H.E.W. in the administration of the Medicare and Medicaid programs have improved the quality of care in most facilities. A large proportion of nursing home patients are non-ambulatory.

Hospitals have been included in the matrix for the purpose of completing the continuum. Few are proprietary. Hospitals could seldom be regarded as a place of residence: long term patients are generally transferred to nursing homes or extended care facilities.

While it is difficult to define discrete boundaries among the eighteen different housing and service packages illustrated in the matrix, basic tendencies do emerge. There appears, for example, to be greater differences among the rows, or dependency levels, than among the columns, or classes of exceptional persons. This would suggest that in some instances it would be possible to have more than one type of exceptional person within the same facility. It is also feasible to mix different dependency levels within the same or adjacent buildings as long as marked differences are avoided.

The matrix was constructed such that occupants of independent and semi-independent housing were considered as being capable of living alone. The presence of a spouse or dependable family support greatly reduces the need of placement in a more protective enviornment. The possible alternatives are further expanded by home health and homemaker services which are sometimes capable of serving all but the most dependent persons. The lines separating the various service packages become even more fuzzy with the obvious realization that one individual can simultaneously belong to two or more categories of exceptional persons - perhaps at differing dependency levels.

Most of our interest in this paper will be focused on dependency levels one through three. More dependent individuals are primarily wards of the health industry. Housing programs at the lower dependency levels can play a significant role in integrating the exceptional person. Institutionalization of the aged can be delayed, if not totally obviated. The rehabilitation of the handicapped and retarded can be accelerated by easing the transition from the hospital or training school to the "real world."

As should be obvious from the above discussion, it would be more productive to organize our study by dependency levels instead of by type of exceptional person. Unfortunately, however, the existing literature does not facilitate such an approach: the current state of the art leaves much to be

desired. First, most of the substantive literature is written by, and addressed to, specialists within the fields of education, medicine, nursing, physical and vocational therapy, public health and social work reveals little evidence of cross fertilization among the various professions. Second, the literature is usually either too general or too specialized to be of much relevance to one charged with designing operational programs for exceptional persons. Third, there appears to have been relatively little effort expended to arouse the interest of the private sector. Even less effort is invested in providing constructive guidance to the emerging residential care industry. Many authors have successfully and properly incensed the public about existing conditions, e.g., the Nader expose of nursing homes (125). Few, however, provide substantive direction to the growing body of concerned citizens.

It is not my intention to disparage specialized research in gerontology or rehabilitation but to demonstrate the need for the development of substantive and comprehensive models of improved service systems for exceptional persons. What is needed now is an approach similar to that of William Michelson in his Man and His Urban Environment (713). This synthesis of existing research attempts to provide operational guidelines to planners and constructive criticism to those engaged in social research. While this paper does not even begin to present guidelines as precise and as relevant as those of Michelson, it does attempt to make a step in that direction.

This paper is primarily a source book which attempts to encourage the reader to engage in operationally oriented research. Each of the following three chapters on the aging, physically handicapped and mentally retarded briefly presents: (a) the characteristics of that population, (b) a description of existing programs and facilities, (c) a discussion of idealized models of optimum care, and (d) an analysis of the constraints frustrating the improvement of present conditions.

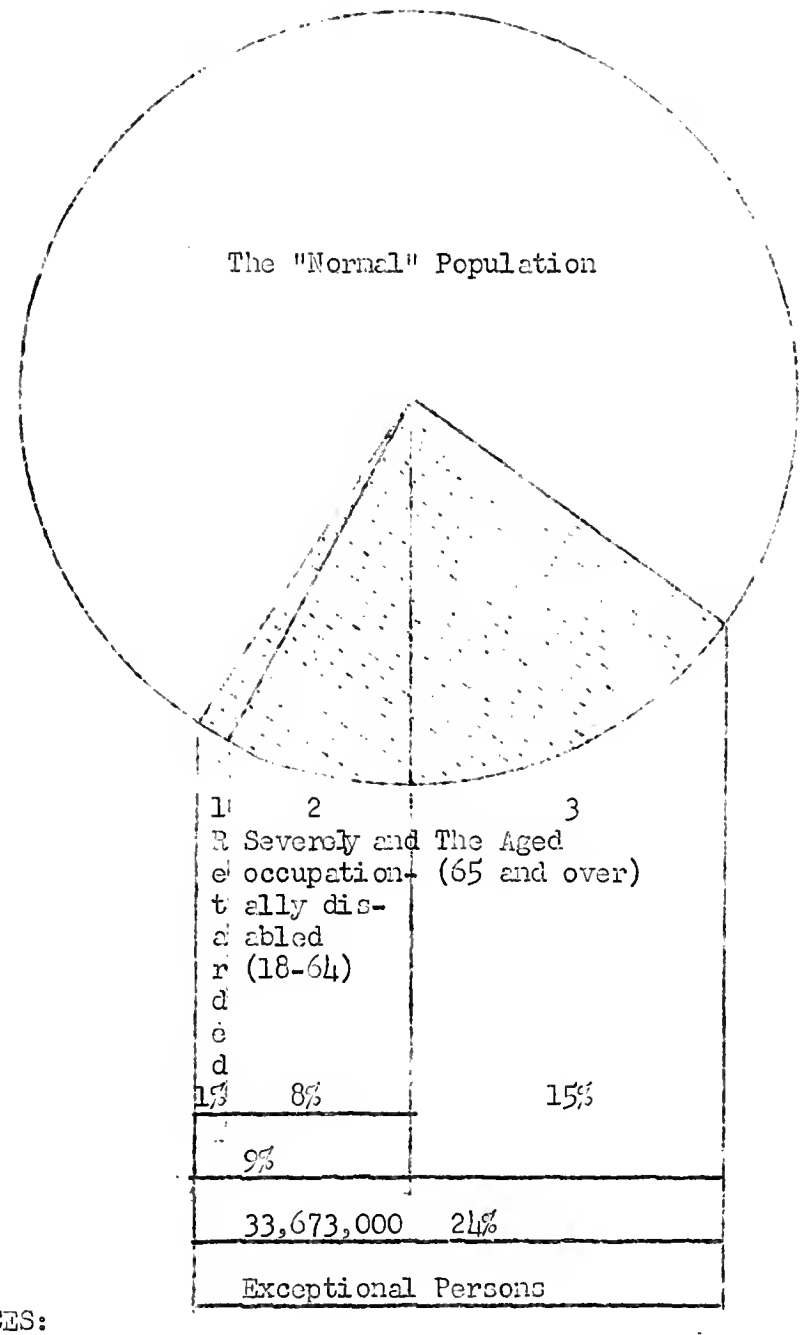
Frequent references are made to the literature, the number in parentheses indicating the index number of the bibliography entry. The bibliography is heavily weighted towards sources which are concerned specifically with housing and operational aspects of program design and administration and should contain most of the relevant literature published since 1960. These are outnumbered, however, by secondary sources pertaining to aspects of care or the social and psychological characteristics of exceptional persons. These have been included as background material. Most entries in this category are from material published after 1967, with more generalized sources being limited to those published within the last two years. Articles from foreign journals were usually excluded. The vast majority of the literature cited in the bibliography should be available in the public and university library systems of most major metropolitan areas.

Of more interest to the serious student are the lists of organizations involved in research, program development and public education. These sources should enable the reader to update this bibliography and to obtain information most relevant to his specific needs.

17. CPL Exchange Bibliography #472-473-474

ESTIMATE OF EXCEPTIONAL PERSONS AS PERCENTAGE OF

ADULT (18 and over) POPULATION IN THE U.S. - 1970



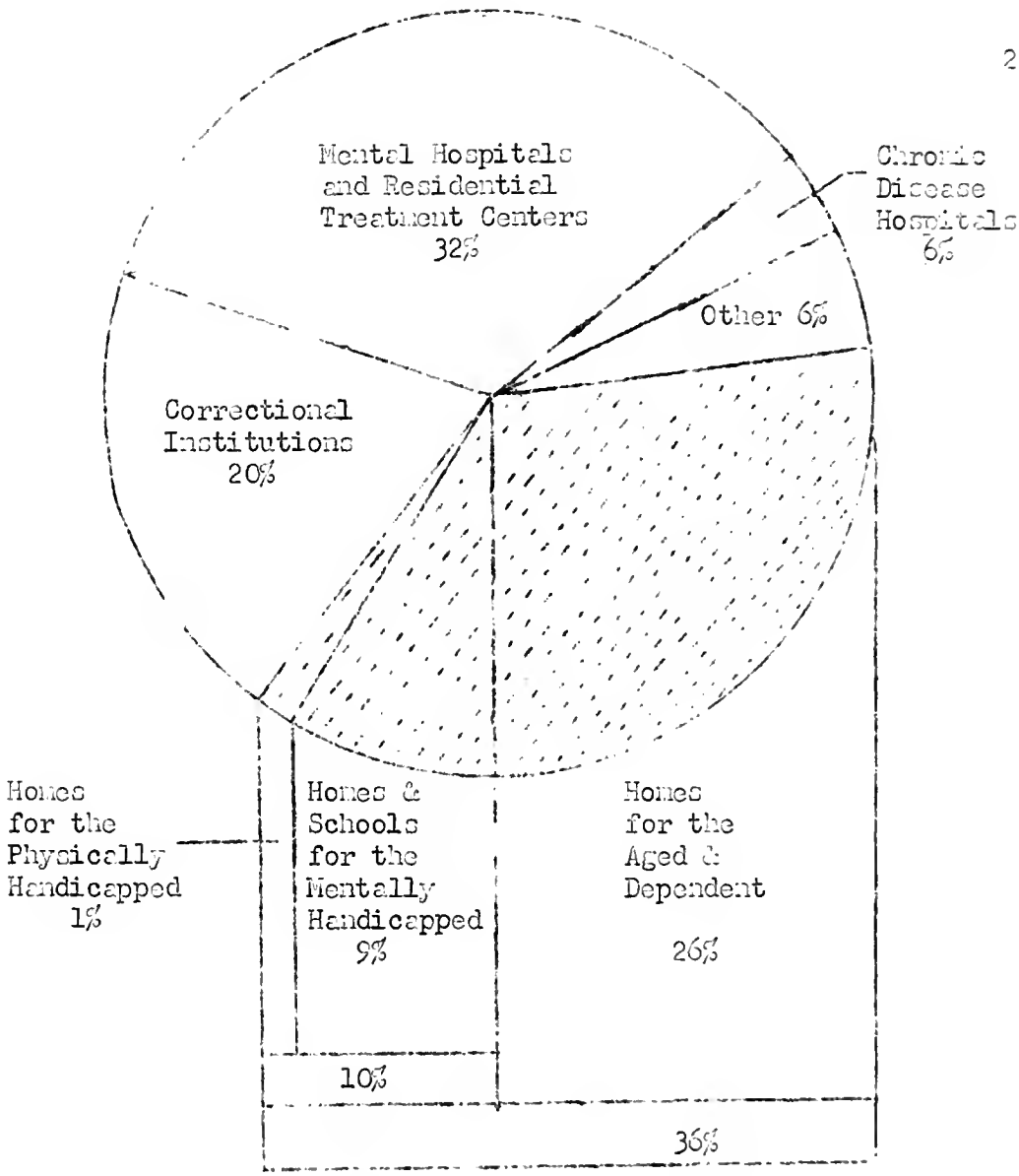
SOURCES:

1. Bernard Farber, Mental Retardation, 1968.

2. Allan & Cinsky, Social Security Bul., 9/72.

3. Bureau of the Census, Statistical Abstract, 1971.

INMATES OF INSTITUTIONS BY TYPE, 1960



SOURCE: U. S. Bureau of the Census, Statistical Abstract, 1971.

	aged	handicapped	retarded
HOUSING:	INDEPENDENT	INDEPENDENT	INDEPENDENT
SERVICES:	minimal intervention: transportation, heavy cleaning & general home maintenance.	same as aged plus additional aid where mobility & strength are limited.	no personal care; minimal supervision: vocational & family counseling.
1			3
HOUSING:	SEMI - INDEPENDENT	SEMI - INDEPENDENT	SEMI - INDEPENDENT
SERVICES:	services adjacent residence - catered meals, homemaking assistance.	same as aged.	same as aged; greater supervision and custodial care.
2			
HOUSING:	BOARDING HOME	BOARDING HOME	BOARDING HOME
SERVICES:	all meals; cleaning, some personal care (dressing, bathing, etc)	same as aged.	same as aged; travel outside facility carefully monitored.
3			
HOUSING:	INTERMEDIATE CARE FACILITY	INTERMEDIATE CARE FACILITY FACILITY	"STATE SCHOOL"
SERVICES:	as above plus minimal medical care.	same as aged.	as above; greater supervision & segregation
4			
HOUSING:	SKILLED NURSING HOME	EXTENDED CARE FACILITY	"STATE SCHOOL"
SERVICES:	personal care plus intermediate medical attention.	same as aged.	as above.
5			
HOUSING:	HOSPITAL	HOSPITAL	MENTAL HOSPITAL
SERVICES:	intensive medical and personal care.	intensive medical and personal care.	maximum supervision and custodial care - some medical care.
6			

AGED

I. CHARACTERISTICS OF THE AGED POPULATION

A. Twenty million Americans are age 65 or older (Census, 1970).

1. The total U. S. population is aging.

   a. In 1900 only 4.1 % of the population was 65 or older as compared to 9.9% for 1970 (Table 5).

   b. Median age rose from 22.9 years in 1900 to 30.2 in 1950 and then fell to 28.3 in 1970 showing a growth in both youth and aged (Statistical Abstract, 1971).

2. More than a third of the aged are age 75 or older (Table 4).

3. 8.9% of the U. S. population can be classified as aging, ages 55-64 (Table 4).

4. The states with the highest concentrations of aged are: Florida, 14.5%; Iowa, 12.4%; Nebraska, 12.4%, Arkansas, 12.3%; and South Dakota, 12.1% (Table 9).

5. In 1965, the living arrangements of the aged were:

   a. 70.5% in families of two or more members;
   b. 21.8% alone;
   c. 3.4% with other, unrelated individuals;
   d. 4.3% in institutions or group quarters (108).

6. 58% of the aged are women.

7. While 70% of aged men are married, 66% of the women are either single or widows (Table 8).

8. Aged married couples are just about as independent as other couples; 98.5% have their own household as compared to the population average of 98.6% (Census, 1970).

9. While roughly one fourth of all aged, or one third of the aged having children, lived with their children in 1957, this tendency has been steadily decreasing (108).

10. Regardless of living arrangements, 84% of those with surviving children lived within one hour of one of their children in 1962; 33% lived within ten minutes (108).

B. Health

1. The incidence of acute (short term) illness is little or no higher for the aged than for the non-aged, but the days of hospital care and disability are twice as high among the aged (190).

2. There is a significant correlation between age and the incidence of activity-limiting chronic disease: 6% at age 30; 70% at age 80 (51).

3. While 81% of the aged suffer some chronic condition (1963), 32% report no activity limitation and only 15% are unable to pursue their customary activities (108).

4. The leading causes of activity limitation among the aged in 1963 were:

   a. heart conditions, 21.8%;
   b. arthritis and rheumatism, 21.8%;
   c. visual impairments, 9.5%;
   d. hypertension without heart involvement, 8.3%;
   e. mental and nervous conditions, 5.8% (108).

5. The aged spend over six times as much as youth on health care ($861 v. $140) and almost three times as much as those in the intermediate age groups ($323)(221).

6. The physiological process of aging is characterized by:

   a. gradual tissue disication;
   b. gradual lowering of the metabolic rate;
   c. gradual retardation of the rate of cell division, growth and repair;
   d. celluar atrophy, degeneration, increased cell pigmentation and fatty infiltration;
   e. gradual decrease in tissue elasticity and the atrophy of connective tissues;
   f. decreased speed, strength and endurance;
   g. progressive degeneration and atrophy of the nervous system: vision, olfaction, attention, hearing, memory and mental endurance (190).

7. Approximately 7% of the aged are bedridden or otherwise housebound (190).

8. A Cornell University study of a large sample of ambulant aged revealed difficulties in:

   a. bathing and dressing, 15%;
   b. climbing stairs, 37%;
   c. walking one-half mile, 33%;
   d. cleaning, cooking, shopping, 35%;
   e. washing clothes, 47%;
   f. using buses, 23% (51).

9. The aged suffer significantly more injuries, particularly from falls, than younger persons (108).

10. In terms of the proportion of drivers involved in automobile accidents who were held to be at fault, persons between 70 and 79 years of age are as bad drivers as those under 24; those over 80 are significantly worse (108).

11. Recommended Reading:

    a. Riley (108), general overview;
    b. Hazell (71), general overview;
    c. U.S.D.H.E.W. (139), general overview;
    d. U.S.D.H.E.W. (143), general overview;
    e. Rogers (111), nursing assessment of the aged;
    f. U.S.D.H.E.W. (135), working with older persons;
    g. Jewett (272), factors related to longevity;
    h. Palmore (345), predictors of longevity;
    i. Kasl (274), health and forced relocation.

C. Sociological and Psychological Aspects of Aging

1. There is little evidence of fundamental personality changes induced by aging; most observed changes are environmentally induced (190).

2. There are, however, significant differences in the observed behavior of the aged who are generally:

   a. less tolerant of ambiguity, more likely to endorse extreme responses, more dogmatic;
   b. more consistent in social and political attitudes;
   c. more cautious, less impulsive;
   d. more introverted;
   e. more conscious of their health and safety;
   f. somewhat less achievement oriented (108).

3. Most, if not all, of the above differences may be more highly correlated to education, socialization patterns and life experiences than to age, per se.

4. The evidence on the degree of irritability and boredom is inconclusive, suggesting the absence of significant differences (108).

5. While little change in the level of self-confidence has been observed throughout the life cycle of women, self-confidence for men increases in their middle years and decreases after age 65 (108).

6. Substantial proportions of the aged do not consider themselves to be old, regardless of the measures employed (108).

7. Widows and widowers, the retired and unemployed, and those in poor health are the most likely to perceive of themselves as being old (108).

8. Popular stereotypes of the aged contain both positive and negative aspects which are shared by young and old alike.

   a. The poor health of the aged is underestimated.

   b. Middle class respondents tend to stress relaxation, leisure and security in describing retirement; working class persons are more likely to emphasize poor health and senility (108).

9. The aged are less inclined than younger people to define their problems as suitable for outside help, either informal (family or friends) or professional.

   a. Regardless of the level of education, the aged are more likely to rely upon themselves, frequently resorting to prayer.

   b. Cohort differences apply more to the definition of problems than to the actual method of attempted solution; sources from which help is actually received do not differ significantly with age (108).

10. Contrary to popular stereotypes, the aged are more interested in world affairs than younger persons, although they tend to be more pessimistic (108).

11. Aging appears to be highly correlated with an increasing incidence of psychosis (4%-8% of those over age 65) (108).

12. A similar correlation does not appear to exist for neurotic conditions (108).

13. Patterns of withdrawal in the face of complexity decline markedly with age (108).

14. "Free floating" anxiety rises with age in women, but not among men (108).

15. Institutionalization of the mentally ill and the use of out-patient mental health clinics declines with age (108).

16. Suicide rates increase significantly with age and are higher for men than for women (108).

17. The scarcity of productive and meaningful roles within society is generally considered the most serious and prevalent social problem of the aged.

18. Recommended Reading:

    a. Atchley (30), social gerontology;
    b. Britton (43), longitudinal study of personality;
    c. Burr (47), psychological functioning of the aged;
    d. Field (60), family and community;
    e. Hoffman (73), needs and interests of the aged;
    f. Riley (108), general overview;
    g. Bloom (202), assessment of functioning;
    h. Cutler (223), political attitudes of the aged;
    i. Gordon (251), self concept and dependency;
    j. Haider (261), mental illness among the aged;
    k. Mueller (313), resocialization of regressed aged;
    l. Turner (392), adaptation to institutions;
    m. Saul (410), family factors and institutionalization.

D. Income and Wealth

1. Studies of the income, wealth and standard of living of the aged rapidly become obsolete due to numerous changes in public programs and rising costs of living.

    a. The best source of information is probably the Social Security Bulletin.

    b. No existing publication, however, presents an accurate and comprehensive analysis of the economic aspects of aging.

2. Only 8.5% of the aged were employed in 1970 (Census).

3. As contrasted to a population median family income of $9,433 in 1969, the median incomes for the aged were only:

   a. $3,373 for married couples;
   b. $1,692 for single men;
   c. $1,227 for single women, (Census).

4. This income came from numerous sources:

   a. about 86% of all aged persons received OASDHI benefits;
   b. 60% of aged couples and 45% of the single persons received income from personal assets;
   c. about 30% of the couples, 24% of the single men and 13% of the single women received private and/or non OASDHI public pensions;
   d. 46% of the couples and about 15% of the single persons received some income in wages;
   e. about 11% received veterans' benefits;
   f. 6% of the couples, 14% of the single men and 16% of the single women received public assistance (Census, 1970).

5. The average monthly Social Security (OASDHI) payments in 1970 were $93.77 for women and $115.30 for men (Census).

6. The average monthly Old-Age Assistance payment was $78 in 1970 (Census).

7. Rather than raising the standard of living for our nation's aged, Medicare, Medicaid, property tax abatement and similar programs may serve only as attempts to neutralize the effects of inflation; even in this modest capacity they may be unsuccessful.

8. While Social Security Benefits, for example, have generally kept pace with rising prices, they have fallen gravely behind in terms of the expansion of household purchasing power or national standard of living (108).

9. The above pessimism can be reduced somewhat through the realization that most data underestimates the non-income wealth of the elderly.

   a. One-half of all aged households classified as poor in 1968 had assets (excluding home equity) greater than $1,200; the median value of the financial assets of the non-poor aged was $6,000 (314).

b. 44% of the non-married poor and 71% of the married aged poor owned their own homes, mostly free of debt, compared to 77% of the non-poor aged (314).

c. Average home equity for aged home owners was about $11,000 in 1970 (314).

d. If the financial assets of the aged were pro-rated over the expected life of the holder, median income would be increased by about 10%; if equity in the home were added, income would rise another 20% (108).

10. A series of simulation projections of the economic status of the retired aged "forecast some improvement in the incomes of retired people;" it also suggests, however, that "there will still be a sizable proportion" of aged in poverty by 1980 (117).

11. Recommended Reading:

a. Bureau of the Census, Statistical Abstract, 1971;
b. Kreps (80), life cycle studies;
c. Schulz (117), 1980 projections;
d. U.S.D.H.E.W. (157), general overview;
e. Murray (314), home equity and financial assets.

D. Consumer Preferences

1. Except for some similarities in income, health and cohort experiences, the aged are as heterogeneous in their tastes and life-styles as the total population; accordingly, any report claiming revelations of "universal" preferences of the aged is spurious.

a. Housing market analysis for the general population is inadequate both in quality and quantity, further complicating the task of determining the perferences and needs unique to a specific group.

b. Existing studies of the housing preferences of the aged doubtless contain a high degree of sampling error and are strongly biased by socioeconomic class and regional differences; while the findings appear to be contradictory, each may be correct when generalization is limited to the specific.

c. Nowhere are the above observations more appropriate than in the current controversy regarding age segregation in housing.

2. Age segregated housing such as H.U.D. insured high-rise apartments for the elderly is condemned because:

   a. The exclusive company of older persons and the resulting high visability of illness and death is considered by many as being damaging to morale, and possibly, to one's immunity from disease (189).

   b. The presence of younger persons is said to foster continued socialization and continuity and to prevent a narrowing of interests and an excessive concentration on the problems of aging (189).

   c. A few controlled experiments have been conducted which support age integration; age integrated psychiatric wards, for example, have been found to be conducive to better health and morale among the aged patients (013).

3. Age integration, however, also has negative consequences:

   a. Younger neighbors are considered by some as making the aging person more aware of his failing abilities (013).

   b. A "normal, integrated neighborhood" only serves to insure isolation in an age graded society; "the field of eligible new friends is thin and scattered (189)."

   c. Special group housing, on the other hand, "serves to concentrate rather than diffuse the field of potential friends and support, thereby maximizing the conditions of social integration (189)."

4. The effects of age segregation actually vary considerably among various individuals and appear to be correlated with life style and personality patterns; cosmopolitan and introverted persons, for example, prefer less and more homogeneity, respectively (013, 713).

5. The propensity to prefer age segregated housing has also been found to be somewhat correlated with socio-economic class; Rosow and others have noted that working class aged tend to confine their friendships to the immediate neighborhood to a greater degree than do middle and upper class aged (370, 713).

6. While the question of age segregation is critical to the problems of the aged and warrants intensified research efforts, it is important that we immediately recognize individual differences and provide a variety of housing choices along the age segregated - age integrated continuum.

7. A sample of aged and a sample of younger persons were interviewed to obtain their preferences regarding neighborhood design; the elderly emphasized homogeneity, image, privacy and friendliness significantly more than did the younger sample which was more concerned with the quality and convenience of public services (190).

8. All housing market research is of limited value in predicting consumer behavior, particularly that of the aged, because:

   a. subjects are not fully aware of alternative choices;
   b. subjects are not aware of many aspects of their own behavior and motivations;
   c. desires and needs are often not congruent and are sometimes even contradictory.

9. Recommended Reading:

   a. Snyder (013), review of the literature;
   b. Wilson (190), neighborhood preferences;
   c. Rosow (370), integration of the aged;
   d. Michelson (713), neighborhood design.

II. EXISTING PROGRAMS AND FACILITIES

A. Independent Housing

1. Assuming that about 15% of the aged live with relatives and 4% live in institutions or group quarters (108), about 80% maintain their own households.

   a. Almost all of these approximately twelve million households reside in conventional housing (including mobile homes).

   b. These persons, while comprising only about 8% of the population, utilize about 20% of the nation's housing units.

c. Many aged live in older urban areas with the problems of personal safety, poor commercial and public services, property maintenance and deteriorating housing added to the inherent problems of aging.

d. The aged appear to be more adversely affected by forced relocations associated with urban renewal and highway construction (102).

e. Those long established within a particular neighborhood have friends and other community ties, but these frequently dwindle over the years with little replacement (108).

f. Those desiring or forced to move have difficulty finding a suitable unit which they can afford; households with incomes less than $6,750 (for two persons) are theoretically eligible for rent supplements under the HUD Section 236 program.

   (1) These subsidies are limited to units specifically approved for the program prior to construction or renovation.

   (2) Demand for such units greatly exceeds supply.

   (3) Expansion of the 236 program has been curtailed by the recent federal moratorium on publicly assisted housing construction.

g. The aged are the group with the least propensity to move; only 30% moved within a five year period and only a third of these moved to a different county; of those moving:

   (1) 16% desired a change of climate;
   (2) 16% desired a cheaper accommodations;
   (3) 20% desired a better and/or different type of dwelling unit (108).

h. Strong attachment to the present neighborhood, both friends and community facilities, is by far the most frequent reason given for being unwilling to move (108).

2. While occupied by a minority of the elderly, age segregated housing has become increasingly available during the last decade.

a. In 1970, 250,000 units of public housing were reserved especially for the aged and the handicapped; this figure comprises approximately 2% of the dwelling units occupied by the elderly and only .4% of the nation's total housing stock (Census, Statistical Abstract, 1971).

b. Many other units have been built under the FHA Section 202 program which authorized fifty year, 100% mortgages at 3% annual interest to sponsors of non-profit rental housing for the elderly and the handicapped; this program is now inactive with H.U.D. reportedly redirecting the funds through the 236 program which has lower maximum income limits.

c. Still other units are built by private investors but are insured by H.U.D. and thus are subject to certain federal standards for design, construction and management.

d. The frequent use of mid and high-rise construction in the above programs results in concentrations of aged way beyond that which could be considered desirable even by the strongest proponent of age segregation.

3. Retirement Communities

a. The retirement community is a phenomenon worthy of intensive study by all concerned with housing for exceptional persons; much excellent literature is available (032, 069, 189).

b. Many apartment buildings, mobile home parks and even some small subdivisions exclude children and young adults; the true "retirement community", however, is primarily confined to Florida, California and Arizona.

c. California, long a leading innovator in housing patterns and life styles, had 38 retirement communities in 1966 with a total of more than 40,000 dwelling units containing 4% of the state's aged population and with another 80,000 units planned for the immediate future (032).

d. The 23 retirement communities studied by Barker (032) had the following characteristics:

(1) totally planned community, 93%
(2) close to regional recreation, 80%
(3) close to regional shopping, 73%
(4) close to a major urban area, 67%
(5) insulated from the adjacent community, 60%
(6) special design for the elderly (considered a liability) 40%
(7) maintenance of landscaping, 82%
(8) organized social program, 76%
(9) full time administrative staff, 71%
(10) public transportation to site, 29%
(11) resident medical doctor, 18%
(12) health insurance provided, 12%
(13) guarded main entrance, 6%
(14) an average minimum age of 48;
(15) 63% of the dwelling units were single family, detached homes, 26% were apartments and 11% were row houses;
(16) about half of the residents were fully employed;
(17) 50% of the home loans were F.H.A. guaranteed, the balance being conventional mortgages with 30-40% down-payments;
(18) average monthly payments were $160 with a down payment of $1,800;
(19) average community size was 1100 dwelling units;
(20) the land use patterns of these communities differed significantly from those of "conventional" subdivisions:

	retirement community	conventional subdivision
housing	74%	76%
recreation	22%	4%
commercial	4%	9%
schools	0%	11%

e. While health facilities were "conspiciously absent" from the California retirement communities (032), the residents of such communities appear to have caused little, if any, drain on the health and other social services of adjacent communities; this results because:

(1) The residents are "more heterogeneous than we might think" in terms of age and wealth.

(2) The communities have positive images in the eyes of residents and applicants and are neither perceived nor employed as "places of the last resort."

(3) The populations of the California style retirement communities do not age markedly because phased construction and intensive consumer demand generate a continuous supply of younger and more active residents.

(4) All applicants are medically screened.

(5) "Not all aged are seriously ill," e.g., a 100 bed retirement hotel has only two deaths and two transferals to nursing homes a year (069).

4. Home Health and Personal Services

a. Many services normally associated with resident institutions or out-patient clinics can be provided to persons in independent housing.

b. Home health service is a term which encompasses a wide range of medically related services including nursing, medical social work, nutrition, physical, occupational and speech therapies, dentistry and homemaker-home health aide services.

c. The marked growth in home health services in recent years has resulted from:

(1) the shift from acute to chronic disease as the major health problem;

(2) the escalation of hospital and nursing home costs;
(3) insurance and pre-paid health plans which have enabled more and better health care;
(4) the limited financial resources of the aged, their limited eligibility for health insurance and their greater need for health services;
(5) a desire to reduce the costs of public assistance;
(6) the growing realization that home care is, in some cases, preferable to institutional care (722).

d. The vast majority of all home health agencies are non-profit public or voluntary organizations; services are provided at cost, supplemented, where necessary, by public assistance.

e. There is great diversity in the organizations which may offer home health services; these include county health departments, visiting nurse associations, community hospitals, medical centers or independent organizations created specifically to provide such services.

f. There is also diversity in the number and intensity of services provided by home health agencies; services include:

(1) single service programs, e.g., nursing;
(2) multiple service programs, e.g., nursing and therapy;
(3) coordinated home care programs covering the full range of services from meals and housekeeping to nursing (721).

g. While comprehensive, centrally administered and coordinated programs greatly enhance the economy and effectiveness of home health care, they are lacking in all too many communities.

h. Developers of housing for the aged and other exceptional persons should carefully appraise the needs of their prospective residents in relation to existing home health and personal services - while the organization of home health services is a complex and frustrating task, the personal aspects of home care are often more in demand and can easily be provided.

i. Volunteer meals on wheels programs serving hot dinners and cold suppers to shut-ins are becoming increasingly popular; alternatives include contractual arrangements with catering firms or university cafeterias.

j. Adequate transportation is extremely critical in maximizing the independence of exceptional persons.

(1) Many cities are experimenting with reduced or waived transit fares for senior citizens.

(2) More personalized transportation is needed, particularly in suburban areas; vans or small buses could be operated either by a taxicab company or by a non-profit cooperative.

k. Housekeeping and maintenance services are also in demand but tend to be small and disaggregated; larger, more centralized programs could assist more persons at lower costs.

l. Assessing one's needs and making all the necessary arrangements necessary for an adequate program of home care is a substantial problem for the uninitiated: the Personalized Service Bureau of Rochester, New York answers these needs by:

(1) arranging for visits by all relevant home health specialists;
(2) making appointments and escorting patients to the appropriate medical office or clinic;
(3) arranging for the cleaning and repair of the partient's home;
(4) assisting in shopping;
(5) modifying the home, especially stairs, kitchens and bathroom to facilitate use of a wheelchair or crutches;
(6) periodically notifying out-of-town family members of an elderly person's situation;
(7) providing personal counseling.

5. Recommended Reading:

a. Christison (053), manual on retirement housing;
b. Niebank (102), relocation of the elderly;
c. Osterbind (104), conference on independent housing;
d. Robbins (110), position paper for White House Conference;
e. Aldergate Foundation (192), financing housing for aged;
f. Ehrlich (230), life-styles in age segregated housing;
g. Montgomery (308), housing patterns of aged;
h. Sherman (382), housing patterns of well aged;
i. Buttrick (404), sociological aspects of housing;
j. Barker (032), California retirement communities;
k. Walkley (189), California retirement communities;
l. O'Neil (341), Sun City, Arizona;
m. U.S.D.H.E.W. (721), home health - planning;
n. U.S.D.H.E.W. (722), home care, general;
o. U.S. Senate (728), home health care, policy.

B. Semi-Independent Housing

1. Little of substance has been written about semi-independent housing; while it appears to exist in several areas, there is no reliable data from which to determine the extent and nature of such housing.

2. Most semi-independent housing in the U.S. appears to be administered in conjunction with a boarding or nursing home and is often church affiliated.

   a. The best of such complexes are characterized by long waiting lists and waiting periods of up to ten years.

   b. A large initial cash payment is frequently required in addition to the monthly rental payment.

   c. In some cases units are sold on a condominium basis with a monthly charge for services.

3. Experimentation in the provision of semi-independent housing need not be delayed by the dearth of published research.

   a. Semi-independent housing is really just a more structured application of home-care services to conventional cottages or apartments.

   b. There doubtless exists a very strong latent demand for such housing as judged by the low vacancy rates of current facilities and the expressed desire of many aged persons for greater convenience and security with the dignity and privacy afforded by being able to maintain their own household.

   c. A hypothetical complex of 100 apartments administered in conjunction with a 100 bed boarding home could offer the following for about $350 a month:

      (1) a 750 square foot, one bedroom apartment in a mid to high rise building proximate to a major regional shopping and office complex;

      (2) five hours a week of personal assistance;

      (3) one high quality warm meal a day;

      (4) 24 hour emergency service with call bells in each apartment;

      (5) free minibus service to points along a scheduled route plus personalized trips at nominal rates;

   d. The same unit could be purchased as a condominium for about $21,000 with a $175 monthly charge for services.

e. These figures, as high as they may seem, are probably competitive with independent housing when the cost of equivalent home care is added to the conventional costs of home ownership or apartment rental.

f. The above amount is clearly preferable to the average monthly cost of $550 a month in a boarding home of comparable quality.

g. Cost comparisons between different types of facilities are quite misleading, however; the services of a given alternative must be viewed in terms of the actual needs of the person in question.

h. A move to a semi-independent housing complex would probably be appropriate if a given individual:

(1) could not obtain suitable home care;
(2) considered his current residence inconvenient, too large, substandard or too isolated from desired activities;
(3) could not depend on the assistance of family or friends;
(4) had a disability which limited him in some activities but was mentally alert and competent to assume responsibility for all his own needs and activities.

4. Recommended Reading:

a. Great Britain (066), flatlets for the aged;
b. Mierstag, (103), Scandinavian designs;
c. Williams (401), consumer preferences.

C. Boarding Homes

1. The boarding home represents another relatively unknown and underutilized facility type.

2. The term "boarding home", as it is used here:

a. is synonymous with doriciliary care facility, residence for adults, personal care home, rest home, home for senior citizens, private proprietary home for adults (P.P.H.A.);

b. describes group housing in which the residents receive full residential care (meals, housekeeping, etc.);

c. describes a level of care for persons not willing or able to maintain their own households but not requiring continuous medical supervision; a comparison between nursing home patients and boarding home residents can be found in table 10;

d. describes two sub-categories of facilities:

(1) residences for adults, similar to hotels, providing all meals and housekeeping services;

(2) personal care homes, often the same facility as above, providing personal assistance in dressing, feeding, bathing, etc.

3. The specific functions of boarding homes vary from state to state and are usually delineated by local legislation.

a. Some states, e.g., New York, license and periodically inspect all boarding homes (099, 100).

b. Other states, e.g., Pennsylvania, leave the regulation of boarding homes to their individual counties.

4. National data on boarding homes is compiled in conjunction with surveys of nursing homes and is summarized in table 9.

a. Boarding homes are presumed to be the majority of facilities listed as "other related facilities", but this figure also includes unaccredited nursing and convalescent homes.

b. Boarding homes giving intensive personal, but no medical care, may have been classified as intermediate care facilities.

c. Residences for adults were probably excluded.

d. Based on these questionable figures, there appears to be one boarding home bed for every four nursing beds.

5. There would appear to be a definite shortage of suitable boarding homes.

a. Personal care has traditionally been limited to small, family type or foster homes; while these frequently provide adequate care in a non-institutional setting, they are often remote from responsible governmental supervision and seldom meet acceptible construction standards.

b. Many states are systematically revoking the licenses of substandard homes as soon as replacement beds become available in an approved facility; thus the number of residential and personal care beds remains constant in many areas in spite of the addition of new facilities.

c. Common sense would lead one to question that only one-fourth as many persons need personal care as need nursing care; properly administered, personal care can forestall, if not totally obviate, the necessity of more intensive medical care.

d. In Monroe County, New York, for example, approximately 500 new personal care beds were created and filled within a two year period.

6. The following examples are taken from New York State; the assistance of the State Board of Social Welfare is gratefully acknowledged.

a. All facilities providing domiciliary care must be licensed; these include:

(1) homes for the aged, voluntary, non-profit facilities for the care of the elderly not operating infirmaries (Institutions providing nursing care are under the supervision of the Department of Health);

(2) public homes, facilities for adults operated by a local social services district;

(3) private proprietary homes for adults (P.P.H.A.'s), providing personal care for compensation and profit;

(4) residences for adults, providing only residential care;

(5) non-profit residences for adults, temporary homes-missions, shelters, etc.

b. All facilities must meet specified construction codes and be equipped with an automatic smoke detector system; while these codes are rigorous, they are less demanding than those applied to hospitals and nursing homes.

c. Operating standards pertaining to the admission of residents, staffing and the provision of services are carefully delineated and enforced through semi-annual certification inspections.

d. Rates in new P.P.[illegible]A.'s average $18.00 a day ($540 a month) for an air conditioned, private room with a private bath and $15.00 ($480 a month) for a shared room.

e. County boards of public assistance are apparently willing to authorize vendor payments of up to $15.00 a day for public assistance recipients.

(1) Welfare recipients in the New York facilities reportedly tend to be more senile and dependent than other residents; consequently, many of the more desireable facilities have placed quotas on the proportion of such recipients (frequently 40%) they will accept claiming:

(a) that a higher proportion of confused and dependent persons would have a damaging effect on the morale of the more independent residents;

(b) that they could not provide intensive personal care to more persons without expanding their staffs and raising rates.

(2) Many facilities are almost completely filled with highly dependent persons.

(a) These are frequently former hotels, often within the central business district, which have difficulty attracting "private" consumers; despite their disadvantages, they offer good access to libraries and other public facilities.

(b) Once a facility admits more than 60% public assistance recipients, it is reportedly extremely difficult to attract other residents.

(c) Such facilities often assume the aura of a public institution: few signs of productive activity, confused persons confined to their rooms or wandering aimlessly in the corridors.

(3) Clearly more facilities are needed to achieve a better integration of the more dependent aged.

g. Those facilities which screen their applicants more rigorously and are able to attract more alert residents are able to provide a cheerful and relatively active environment for the care rates as those facilities which primarily house public assistance recipients.

h. The more attractive facilities average about 80 beds in size and are generally one story structures sited on wooded suburban lots; their only shortcomings appear to be:

(1) their isolation and the absence of either mini-bus or public transportation;

(2) the lack of opportunities to personalize one's room with one's own furniture and to choose paint color, carpets, drapes, etc.

i. Managers of new P.P.H.A.'s (haphazard sample) indicated that:

(1) single rooms are the most popular, despite their higher cost;

(2) there is a demand for large double rooms for married couples - virtually none are provided.

7. Recommended Reading:

a. American Nursing Home Association (026), statistics;
b. New York State Board of Social Welfare (099, 100), regulations governing operation of P.P.H.A.'s;
c. Richman (357), financial aspects of boarding homes.

D. Nursing Homes

1. While skilled nursing homes and intermediate care facilities could be viewed as entities of the health industry, they should be of more than peripheral interest to students of housing for exceptional persons.

a. Three per-cent of the aged population (686,000 persons), are patients of nursing homes (026).

b. Many of these persons, especially those in intermediate care facilities, would not have to be there if:

(1) Medicare and other public programs were more flexible and allowed utilization of other forms of care when such were appropriate.

(2) Home care programs were more numerous, more coordinated in their administration, and more comprehensive in their scope of services.

c. Nursing homes are perhaps the most visible of services provided primarily for the elderly; their image will doubtless affect public attitudes towards expanded services for the aged and other exceptional persons.

d. The literature on nursing homes contains much of relevance to those interested in boarding homes and semi-independent housing, particularly in the areas of nutrition, personnel, recreation and finance.

e. Nursing homes represent an excellent case study of the interface between the private and public sectors in the provision of services; knowledge of the strengths and weaknesses in this experience would be helpful in designing new programs for the aged.

2. Recommended Reading:

a. American Nursing Home Association (026), statistics;
b. Eagle (001), review of the literature;
c. McQuillan (085), nursing home administration;
d. Thomas (124), nursing homes and public policy;
e. Townsend (125), Ralph Nader study;
f. U.S.D.H.E.W. (150), guide for social services;
g. Earle (228, 229), analysis of the industry;
h. Field (235), appraisal and financing;
i. Business Week (240), nursing home industry;
j. Geriatrics (253), proposed intermediate care standards;
k. Greenwald (259), statistics;
l. Handy (262), future of nursing home patients;
m. Henry (266), public policy;
n. McCoy (293), public policy;
o. Markus (296), institutionalization and morality;
p. Marsden (298), nursing home financing;
q. Miller (307), advocacy in institutions;
r. Oppenheim (342), public policy - quality of care;
s. Barrons (346), case study of nursing home chain;
t. Rolland (361), case study of nursing home chain;

u. Russell (373), impact of Medicare on industry;
v. Van Nostrand (395), nursing home employees;
w. West (399), five years of Medicare, statistics.

III. IDEALIZED MODELS OF OPTIMUM CARE

A. In an optimum system of services for the aged, housing and other physical facilities would be of only secondary importance.

1. A comprehensive and substantive program of income maintenance would benefit all Americans.

a. The greatly expanded personal income would have a long run beneficial effect on the economy; adequately funded, such a program could be almost self-liquidating by generating new jobs and additional taxable income.

b. Not only would the nation's poor enjoy increased participation in the consumption of goods and services, they would have, through their strengthened purchasing power, an expanded role in determining what goods and services were provided - the private sector would respond, as it has with Medicare, to offer expanded social services: day care, home health care, a greater diversity of housing alternatives, improved transportation, etc.

2. Unfortunately, few of us have the imagination, the faith and the courage to weather short-run disequilibrium in hopes of future gains; an incremental approach focusing on the individual service systems is the inevitable compromise.

a. The income needs of the aged must be thoroughly examined; while we are tinkering, however, some interim measures - such as increased payments through the existing programs (social security, Medicare, Medicaid, housing subsidies, etc.) - must be implemented to reduce some of the blatantly obvious inadequacies.

b. We must stop discarding our citizens at age 65 - such expiration dates should be limited to film, food and medicine and never applied to people.

(1) Occupational mobility should be facilitated through expanded programs of continuing education and the removal of arbitrary requirements.

(2) Greater legitimacy needs also to be accorded to those, especially the aged, who are no longer motivated by the work ethic; more diverse, creative and fulfilling leisure lifestyles need to be developed.

c. The vast potential of home health care has yet to be realized; consumers must obtain greater influence in the planning and administration of our health systems.

d. Inadequate transportation represents a major obstacle to the integration of our aged; expanded public transit systems and personalized minibus services for the less agile would be the single most expedient means of insuring the continued participation of our seasoned citizens.

e. The range of housing choices available to the aged should be greatly expanded; this could be done at little additional cost through the extension of H.U.D. mortgage insurance to boarding homes and semi-independent housing, some well coordinated research and the education of zoning officials and mortgage bankers.

B. While some attempt to restructure society, others should begin immediately at an intermediate level to more fully exploit the potential of existing technology; new communities and planned unit developments are the most appropriate arenas for such activity.

1. While planned residential communities are just being introduced to most parts of the country, those in California have already reached a second level along the evolutionary continuum by offering an extensive range of recreational activities and household services; the provision of a more extensive social services package would simply represent a logical extension of this trend.

2. Our model community would not be one built to accommodate a specific group, such as the aged, but an environment in which the participation of exceptional persons would be so facilitated as to be taken for granted.

3. All buildings would be constructed so as to permit access by the less agile, including those in wheelchairs.

4. The utilization of multipurpose community facilities and comprehensive and carefully coordinated programs would allow maximum services at minimum cost.

   a. A boarding home with an enlarged kitchen would provide meals to those in semi-independent apartments and to those participating in a "meals on wheels" program.

   b. Educational programs could be more flexible and economical through the use of leased space in a multipurpose community center as is being done in the new community of Ganenda, New York.

   c. The public funds which normally would have been invested in the construction of school buildings could be spent for libraries, swimming pools, craft centers and other facilities which would be available to all residents.

5. The personnel employed by the community association and the many services and commercial establishments would primarily come from the community, itself.

   a. Working hours would be flexible so as to accommodate students and working mothers.

   b. Some elderly and handicapped persons could be employed in maintenance and administrative positions for the community association, as day care, recreation and teacher aides and as aides to other exceptional persons.

6. This vast network of community services could be professionally managed by a trustee with the guidance of a tenant's association - in a manner ironically similar to the management of the hedonistic recreational communities of the West Coast.

7. The ideas expressed in this brief and truncated presentation do, indeed, appear naive; the ideas themselves, however, are valid and will work - the precedents are there - we simply have to apply them in a more coordinated and intensified manner.

C. Even the least adventurous among us can act - in the present tense - to improve the environments of our aged; buildings, regardless of their location or source of funding, can be constructed so as to better meet the specific physical needs of the elderly.

1. Probably the best single source of reasonable design criteria is the 1968 Cornell University publication, Housing Requirements of the Aged (051).

2. Living rooms in apartments for the elderly are actively used and should have:

   a. large, unbroken areas to accommodate a large collection of furniture brought from the previous, and usually larger, residence;

   b. picture moldings on all walls;

   c. extra wide window sills for plants;

   d. ample bookshelves;

   e. an extra large storage closet in which to stash junk prior to receiving company;

3. The dining area should contain a direct pass-through to the kitchen and be designed so as to allow the placement of the dining table by a large window.

4. The bedroom should also be large, contain a telephone and/or call bell and provide short, direct access to the bathroom.

5. The bathroom is the area in which the elderly experience the greatest number of accidents.

   a. The room should contain a call bell, a closet in place of the traditional medicine cabinet, recessed soap dishes and be large enough to accommodate a wheel chair.

   b. A stall shower with a bench seat is preferable to a bath rub.

   c. There should be several grab bars and these should be low because pushing is easier than pulling.

   d. The sink should contain a single, lever type mixing faucet to minimize scalding.

   e. The room should not contain any projections other than the grab bars.

6. While the kitchen should be compact to minimize walking and carrying, pullman kitchens are not adequate.

a. The placement of the kitchen in relation to the living room and the entry is important; direct views into the kitchen should be minimized as the aged are frequently not as tidy as they would like to be and do not like to advertise this disability.

b. No cabinets should be less than 27 inches or more than 63 inches from the floor so as to discourage stooping, stretching and climbing.

c. The range and oven should be electric; the oven should be a separate unit hung on the wall at waist level.

7. General Design Standards:

a. non-skid flooring, perferably carpeting, throughout entire apartment;

b. wide doors with little, if any, threshold and without automatic door closers;

c. master keyed entrance doors with peepholes but without dead-bolt locks;

d. sliding cabinet and closet doors;

e. no ceiling light fixtures;

f. all electric outlets at waist level;

g. excellent insulation for both sound control and heat retention;

h. no exposed heat sources, especially under windows;

i. stairs, when these are necessary, should be limited to one flight of uniform steps with shallow risers;

j. exterior fire escapes are terrifying, stairs should be enclosed;

k. elevator cabs should be equipped with benches;

l. exterior pavement should not have curbs;

m. each resident should have access to private, as well as public and semi-public outdoor areas;

n. allotment gardens should be provided to those who desire them (051, 713).

IV. CONSTRAINTS TO INNOVATION

A. The whole concept of normalization depends on using "natural" processes to the fullest extent possible; as these processes involve an infinite number of actors, there are, inevitably, a great many constraints.

B. The aged as Consumers

1. Consumer perceptions of housing alternatives for the aged appear to be limited to two extremes: total self-reliance in independent housing versus commitment to an institution.

2. Even the most rational persons frequently tend to postpone important decisions concerning their personal affairs until forced to respond to a crisis.

a. Older persons often bravely remain independent way past the point when it is no longer prudent to do so and until their condition mandates institutional care.

b. The aging (ages 55-64) need more comprehensive and more substantive pre-retirement counseling to encourage them to move to more protective environments, e.g., semi-independent housing, when such action is indicated.

3. The natural reluctance to acknowledge one's own infirmities is doubtless reinforced by the poor public image accorded nursing homes and group housing for the elderly.

4. There also appears to be little consumer awareness of the potential of home care as a substitute and a deterrent to institutional care.

5. Even with greater consumer awareness of alternatives, however, few of the aged would have the financial resources to support housing innovations.

C. Governmental Leadership and Response

1. While the low incomes of the aged and the high costs of housing and health services indicate the need for governmental fiscal support, such support may be some years in coming.

a. The recent moratorium on federally assisted housing has greatly reduced the number of aged who could afford new forms of housing, even if these were available.

b. It remains to be seen whether general revenue sharing will yield any immediate benefits for the aged, but - given the pressing financial needs of many other, more vocal, groups - this is unlikely.

2. While inadequate income will remain the greatest obstacle to reform, much can be done to assist the aged by removing the many non-financial barriers to innovation.

a. A great many federal agencies are involved in assisting the aged (please refer to the lists contained in the appendix), but this effort is fragmented and needs rigorous coordination and aggressive leadership.

b. It is natural to be more responsive to organized lobby groups and established institutions; unfortunately, however, this tendency works against the relatively voiceless consumer and those who attempt to introduce innovations into the industry.

c. Home health care, for example, deserves a significantly greater share of the government's subsidy of the health industry and recognition by Medicaid and Medicare as a legitimate and often cheaper alternative to nursing homes.

d. The federal government has considerable potential, through its role as the nation's largest employer, for changing policies regarding compulsory retirement; attitudes toward leaves of absence, working hours and rotations of duties could be liberalized to allow periodic changes in routine without complete termination of one's career.

e. A shift from sales and property taxes to a graduated income tax as the major source of revenue for local governments would greatly assist the aged in their battle against inflation.

f. Deficiencies in public services, both in quality and in quantity, impede those attempting to assist the aged in obtaining greater independence; the best designed semi-independent housing will be little better than a public institution if its residents do not have adequate public transportation or are afraid to leave the building.

g. Local zoning ordinances banning multiple occupancy dwellings from residential neighborhoods encourages the segregation of those living in protective environments and forces such facilities either to remote locations or onto expensive land having the required zoning.

h. Failure of the public sector to assume the leadership in establishing clear and adequate standards for emerging industries, e.g., semi-independent housing and boarding homes, deters many potential innovators; investors fear that if they make a premature entry into a new field, particularly in the social services, new governmental regulations will be promulgated which will render their facilities obsolete.

D. The Private Sector: The Development of New Markets

1. Perhaps the most compelling reason deterring the real estate industry from developing innovations in housing for the aged is that while demand may exist, the purchasing power does not; the escalation of land and construction costs prohibits the development of units which can be afforded by the majority of the aged.

2. Even if the purchasing power of the aged were increased, through the proposed housing allowance program, for example, the private sector response may be slow because:

a. New housing types arise not from a response to consumer demand - the industry largely dictates consumer preferences - but from a response to increasing land and construction costs.

b. The profit margins in lower priced housing are not as attractive as those in middle and upper income housing in which the industry is enjoying record sales.

c. The risks are perceived to be greater.

d. Investors may be deterred by governmental red tape, either perceived or real - experience with the Section 236 rent subsidy program has made many developers leery of H.U.D. sponsored housing.

3. Consumer behavior could easily lead developers to think that the existing products are adequate; not only is there little incentive to introduce new housing types; the innovations described above could possible compete with existing, and usually more expensive, products.

4. Developers prefer to deliver a physical product, e.g., an apartment building, and have provided "software" services such as day care and recreational programs only when they could not otherwise avoid it; semi-independent housing and boarding homes with their higher operating costs, liability and long term commitment, would probably not be viewed as being attractive by the builder who prefers to "get in and get out."

5. Semi-independent housing and boarding homes would have more appeal to the nursing home chains who may be seeking diversification while capitalizing on their experience in administering large institutions staffed primarily with paraprofessionals and unskilled labor; it is questionable, however, that such corporations would fully utilize the normalization potential of these housing types.

6. Projects similar to our model P.U.D. would not be attractive to the conventional developers who would be concerned about the project obtaining an institutional image; they could argue:

   a. The availability of housing designed to accommodate exceptional persons would attract a high proportion of such persons, destroying the "balance" which was sought in the original design of the community.

   b. "Normal" consumers would be reluctant to move into the community because of either direct prejudice towards exceptional persons or their fear of declining property values.

7. Many potential boarding home operators may be deterred by the negative image of the nursing home industry; while many people rightfully question whether the provision of such services should be a proprietary activity, the response of non-profit entities, both public and voluntary, has not been adequate to meet the need.

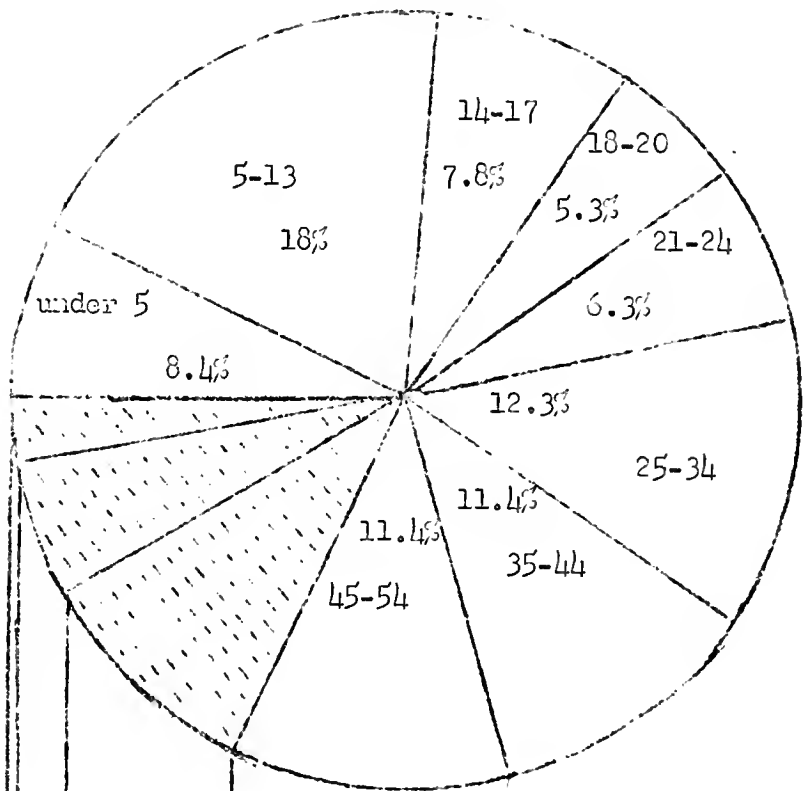
8. Smaller investors will be deterred by the scale required to build an adequate and profitable facility: probably a minimum of fifty beds for a boarding home and one hundred apartments for semi-independent housing.

9. Mortgages will be difficult to obtain for any form of housing for exceptional persons until financial institutions become convinced of the safety of such investments.

AGE DISTRIBUTION OF THE U.S. POPULATION, 1970

SOURCE: U. S. Bureau of the Census

4



OUR AGING POPULATION: 1900 - 1980 5

year	total population	population 65 and over	% of total population
1900	75,994,575	3,083,939	4.1
1910	91,972,266	3,953,945	4.3
1920	105,710,620	4,939,737	4.7
1930	122,775,046	6,644,378	5.4
1940	131,669,275	9,036,329	6.9
1950	150,697,361	12,294,698	8.2
1960	178,464,236	16,559,380	9.3
1970	203,165,699	20,049,592	9.9
1980	(estimated)	25,000,000	

Source: Bureau of the Census

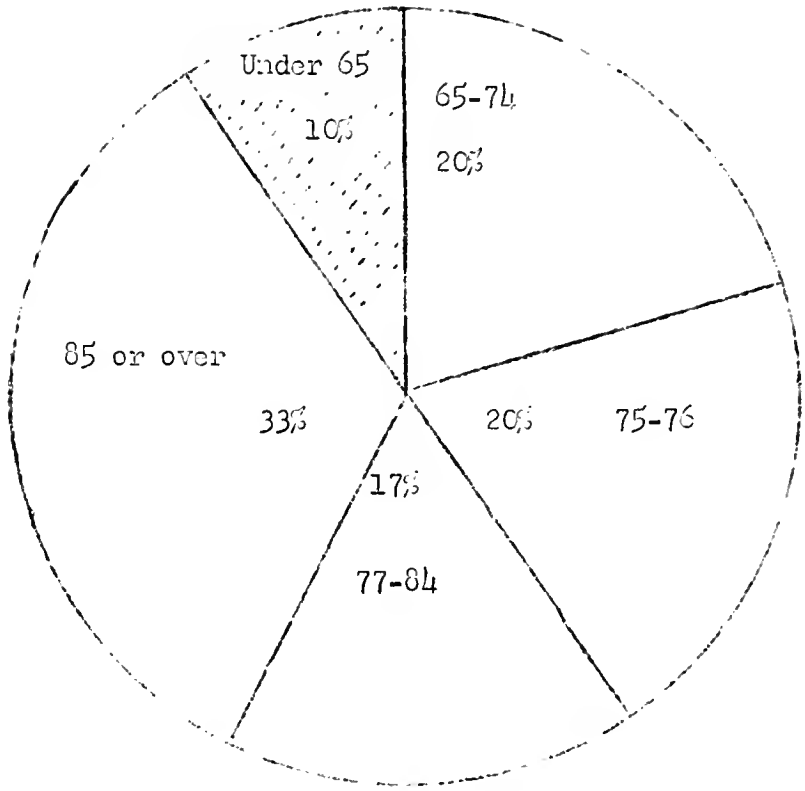
NURSING HOME GROWTH: 1954-1969 6

year	homes	beds	average beds/home
1954	6,539	172,000	26.3
1961	9,582	331,000	34.5
1965	11,981	512,000	42.7
1966	13,151	583,415	44.3
1968	12,912	707,184	53.9
1969	13,047	762,465	58.4

Source: American Nursing Home Association, Nursing Home Fact Book, 1970-1971.

AGE DISTRIBUTION OF NURSING HOME PATIENTS, 1969

7



SOURCE: Nursing Home Fact Book.

SEX AND MARITAL STATUS OF THE AGED, 1970

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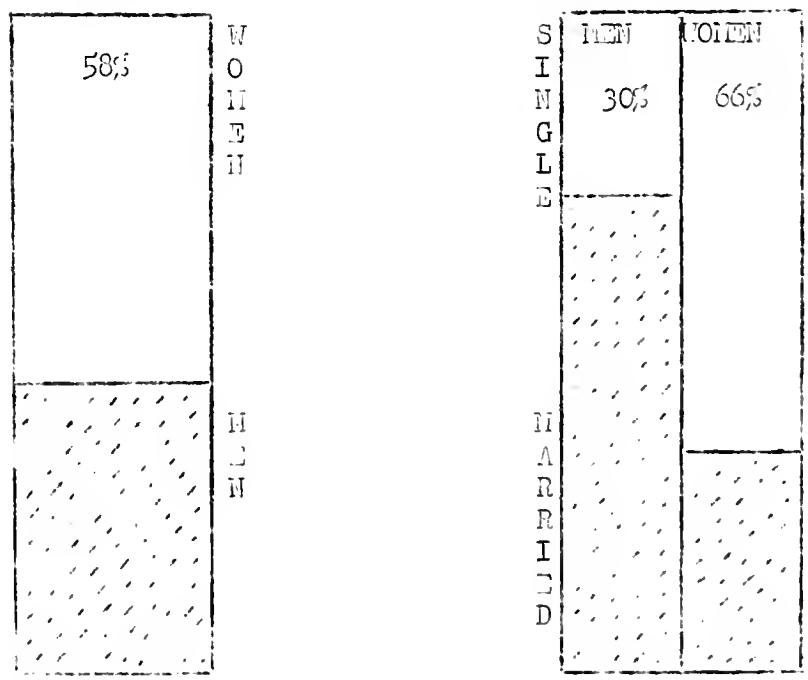

SOURCE: Bureau of the Census, Statistical Abstract, 1971.

State	% Aged	Rank*	Skilled Nursing Home Beds per 1000 aged	Intermediate Care Beds per 1000 aged	Other Related Beds per 1000 aged	Total Beds per 1000 aged	Rank
Alabama	9.5	21	35	2	1	38	43
Alaska	2.2	51	21	-	-	21	49
Arizona	9.2	35	23	-	4	27	48
Arkansas	12.3	28	7	52	-	59	19
California	9.0	2	51	-	25	76	9
Colorado	8.5	33	62	8	6	76	8
Connecticut	9.5	26	53	6	11	70	12
Delaware	8.0	48	21	3	14	38	42
Dist. Columbia	9.4	41	42	-	5	47	30
Florida	14.5	7	21	2	16	39	41
Georgia	8.0	17	45	2	2	49	28
Hawaii	5.7	47	23	-	20	43	35
Idaho	9.5	44	44	8	-	52	23
Illinois	9.8	4	35	-	20	55	21
Indiana	9.5	12	9	33	8	50	27
Iowa	12.4	19	10	61	32	103	1
Kansas	11.8	27	39	-	33	72	11
Kentucky	10.5	20	20	-	29	49	29
Louisiana	8.4	23	44	-	-	44	34
Maine	11.6	36	7	33	19	59	20
Maryland	7.6	24	27	14	5	46	31
Massachusetts	11.2	10	31	25	10	66	13
Michigan	8.5	8	28	9	8	45	32
Minnesota	10.7	15	25	45	16	86	5
Mississippi	10.0	30	20	5	1	26	48
Missouri	12.0	11	19	31	3	53	22
Montana	9.9	43	38	-	27	65	15
Nebraska	12.4	34	13	46	18	77	7
Nevada	6.3	49	27	3	15	45	33
New Hampshire	10.6	39	64**	-	-	64	16

* percentage of nation's aged ** includes other facilities

SOURCE: Derived from Nursing Home Fact Book, 1970.

State	% Aged	Rank*	Skilled Nursing Home Beds per 1000 aged	Intermediate Care Beds per 1000 aged	Other Related Beds per 1000 aged	Total Beds per 1000 aged	Rank
New Jersey	9.7	9	30	-	12	42	37
New Mexico	6.9	42	19	10	2	31	45
New York	10.7	1	26	6	10	42	39
North Carolina	8.1	14	16	-	26	42	40
North Dakota	10.7	45	48	-	44	92	2
Ohio	9.4	5	20	30	-	50	26
Oklahoma	11.7	25	79	-	.5	80	6
Oregon	10.8	29	62	-	13	75	10
Pennsylvania	10.8	3	40	2	-	42	36
Rhode Island	11.8	37	30	22	-	52	24
South Carolina	7.4	32	30	-	5	35	44
South Dakota	12.1	38	36	35	8	79	7
Tennessee	9.8	16	8	18	3	29	47
Texas	8.8	6	21	26	15	62	18
Utah	7.3	40	24	23	15	62	17
Vermont	10.7	46	23	23	19	65	14
Virginia	7.9	18	24	-	16	40	40
Washington	9.4	22	68	6	18	86	4
West Virginia	11.1	31	8	-	12	20	51
Wisconsin	10.7	13	78	-	9	87	3
Wyoming	9.1	50	36	-	14	50	25
AVERAGE:	9.9	-	32	10	12	54	-

* percentage of nation's aged ** includes other facilities

SOURCE: Derived from Nursin , Home Fact Book, 1970.

CHARACTERISTICS OF PATIENTS OF NURSING HOMES & RELATED FACILITIES

	Skilled Nursing Homes	Intermediate Care Facilities	Boarding Homes	All Types
PHYSICAL STATUS OF RESIDENTS:		PERCENT		
cannot walk unassisted	53.3	30.0	17.7	42.0
partially or totally bedfast	52.4	33.2	20.1	42.9
incontinent	33.8	19.4	11.7	26.8
mentally confused, sometimes or always	57.1	42.1	33.2	49.8
PUBLIC ASSISTANCE RECIPIENTS:				
(prior to Medicare)	53.0	42.0	47.9	48.6
PATIENTS ACCEPTED:				
Over 65 only	24.5	36.8	47.1	33.2
Bedfast	94.2	63.2	17.7	68.1
Mentally ill	23.6	31.4	18.5	24.9
P.A. recipients	92.2	90.2	88.3	90.7
SERVICES REQUIRED:				
Medication	66.0		30.0	
Rub & Massage	64.0		11.0	
Full Bed Bath	55.0		9.0	
Help in Dressing	48.0		17.0	
Help in Bathing	42.0		34.0	
Bedpan	39.0		6.0	
Enemas	26.0		5.0	
Help in Feeding	24.0		7.0	

SOURCES: Edward Eagle. "Nursing Homes and Related Facilities, a Review of the Literature." (U.S.) Public Health Reports, Volume 83, Number 8, August 1968, 673-684.

LARGEST PUBLICLY OWNED NURSING AND EXTENDED CARE CORPORATIONS

	Rank by No. Beds	States	Bldg.	Beds
Four Seasons*	1	19	30	5,500
Extendicare* (also operates in Canada)	2	14	40	5,300
Beverly Enterprises*	3	10	40	4,900
Medic-Home Enterprises, Inc.	4	7	30	4,400
Medicenters of America, Inc.	5	30	30	4,300
National Health Enterprises, Inc.	6	5	30	4,300
Century Convalescent Centers, Inc.	7	6	40	4,000
Hy-Lond Enterprises	8	4	40	3,900
Monterey Nursing Inns, Inc.*	9	6	40	3,800
Unicare Health Services, Inc.	10	6	20	2,900
Total:			340	43,300
Percentage of Total Industry, 1970:			3.5%	6.3%

* Also owns and/or constructs hospitals.

SOURCE: Paul W. Earle. "Long Term Care: The Nursing Home Industry." Hospitals, Volume 44, February 16 and March 1, 1970, pp. 45-50, 116-117; 60-64.

The aged comprise about 60% of the exceptional adult population; while their problems are similar to those of the handicapped and the retarded, there are some differences. These will be outlined briefly in the two sections which follow.

HANDICAPPED

I. CHARACTERISTICS OF THE PHYSICALLY HANDICAPPED

A. Approximately 8% of the adult, non-aged population (ages 18-64), or about nine million Americans, are severly and occupationally disabled persons not residing in institutions.

1. While the median age of the total adult, non-aged population is 40, the median age for the corresponding disabled population is 50.

   a. The severely disabled comprise the oldest group of physically handicapped.

   b. The age distribution between the sexes is similar with but one exception: among young adults, relatively more women than men are severly disabled (448).

2. The severely disabled are significantly more likely to be Negro, female and residents of the South than would be expected on the basis of a simple probability distribution (448).

3. The mean number of years of school attendance of the disabled is ten years compared to twelve for the total population (448).

4. Because of the greater dependency of the disabled person on his spouse, marriage in many ways assumes more importance for the handicapped:

   a. 63% of the disabled were married in 1965 as compared to 73% of the non-disabled population.

   b. 9% were widowed as compared to 4% of the normal population.

c. One-third of the disabled head households containing minor children.

d. The average family size of disabled households is smaller.

e. Divorce and separation are more frequent among the handicapped (448).

5. About 8% of the non-institutionalized adult disabled population (ages 18-64) lived alone in 1965 (448).

6. About 60% of the disabled had no relatives residing with them except for their minor children and spouse (448).

7. Of those having relatives (extended family), 23% have no contact with them; 64% visit their relatives frequently but receive no aid; 13% do receive some sort of aid from their relatives (448).

8. A survey of a large sample of handicapped persons conducted in 1965 indicated that about 80% of the disabled men and 60% of the disabled women had been employed at some time prior to the onset of their disability (448).

9. While about 65% of the corresponding normal population were in the labor force in 1966 with an unemployment rate of 3.7%, only 50% of the disabled were in the labor force with an unemployment rate twice as high (448).

10. Only 20% of the severely disabled were in the labor force with an unemployment rate of 12% (448).

11. In the 1965 Social Security Administration survey, the various causes of disability were found to be distributed as follows:

a. Musculoskeletal disorders, 32.8%;
b. Cardiovascular disorders, 23.6%;
c. Respiratory and related disorders, 12.4%;
d. Digestive disorders, 7.5%;
e. Mental disorders, 5.6%;
f. Nervous system disorders, 5.4%;
g. Neoplasms, 1.2%;
h. Urogenital conditions, 1.9%;
i. Diabetes, 2.4%;
j. Visual impairment, 2.5%;
k. Other, unspecified conditions, 4.7% (448).

B. About 7% of all severely disabled persons (approximately one-half million persons) were residents in 1967 of long term medical institutions and schools or homes for the physically and mentally handicapped.

1. The vast majority of these persons were classified as being mentally ill or mentally retarded (242).

2. Only 13.2% of this population were physically handicapped (242).

C. The median income of households having a disabled person in 1965 was only $3,923 (499).

1. The median family income of the severely disabled population was $2,124 and more than 60% of these households had incomes below $3,000 (499).

2. Married men with severe disability had a median household income of $3,133 while married disabled women, as expected, had significantly higher household incomes (499).

3. About 80% of the severely disabled nonmarried adults had incomes less than $2,000 in 1965 and only 7% had incomes greater than $3,000 (499).

4. In 1965 the income of the handicapped was found to be distributed among the following sources:

a. no income, 3.4%;
b. earnings, total, 79.4%;
c. earnings, spouse, 27.2%;
d. earnings, children, 5.3%;
e. earnings, head, 73.9%;
f. public income maintenance programs, total, 37.6%;
g. social security and railroad retirement benefits, 18.6%;
h. veterans payments, 9.2%;
i. workmen's compensation, 1.6%;
j. public employee benefits, 3.2%;
k. unemployment compensation, 2.6%;
l. public assistance, 9.3%;
m. private pensions, 3.5%;
n. other private income, 6.6%;
o. contributions from relatives outside household, 3.9% (499).

D. Recommended Reading:

1. Frolich (242), characteristics of disabled population of institutions;
2. Neff (430), psychological aspects of disability;
3. Safilios-Rothschild (433), sociological and psychological aspects of disability;
4. Stanley (435), assets of the disabled;
5. President's Task Force (443), public policy;
6. Allan (448), general characteristics and statistics;
7. Bachman (451), adjustment of handicapped young adults;
8. Haber (475), problems of statistical measurement;
9. Swisher (499), income of the disabled;
10. Dean (547), public policy.

II. EXISTING PROGRAMS AND FACILITIES

A. Only a minority of the physically handicapped population resides in long term care institutions.

1. Form of ownership:

a. voluntary, non-profit, 70%;
b. governmentally owned, 29%;
c. proprietary, 1% (697).

2. About 80% of the institutionalized handicapped resided in facilities associated with a general hospital (697).

3. Newly disabled persons, who formerly would have been institutionalized permanently or for prolonged periods, are now being encouraged to untilize a growing number of out-patient clinics.

B. The physically handicapped residing in independent housing are affected (in theory) by a wide variety of public services including:

1. public housing;
2. home health care;
3. meals on wheels;
4. specialized transportation;
5. sheltered workshops;
6. physical and vocational therapy;
7. specialized educational programs;
8. personal and family counseling;
9. day care centers;
10. recreational programs;
11. Medicaid and other forms of public assistance.

C. Patterns of facility utilization by non-institutionalized handicapped persons ages 18 - 64 years revealed by a recent Social Security Administration study have important implications on public policy.

1. Only 12% of those eligible reported ever having received social and rehabilitative services; only about 14% reported any intention of requesting such services in the future (504).

2. Facilities do not appear to be turning away eligible clients, however; only about 4% of those who did not receive any services had ever sought assistance (504).

3. Do the above findings mean that we have an adequate supply of rehabilitation facilities; that persons do not perceive them to be helpful; or that more aggressive measures are needed to reach and rehabilitate the disabled?

D. Recommended Reading:

1. Lawton (427), elementary rehabilitation text;
2. U.S.D.H.E.W. (437), public programs;
3. U.S.D.H.E.W. (440), public assistance programs;
4. Fenton (468), long term residential facilities;
5. Grunewald (473), dynamics of residential living;
6. Klien (480), public housing;
7. Kostick (481), day care;
8. Loring (484), international trends in long term care;
9. Richman (490), public policy;
10. Stohl (496), preserving home life for the disabled;
11. Rose (491), employment of the handicapped;
12. Treitel (504), rehabilitation statistics.

III. IDEALIZED MODELS OF OPTIMUM CARE

A. All the goals delineated for the aged are equally applicable to the physically handicapped.

B. While more substantive and dynamic programs of income maintenance are also a salient need of the handicapped, many within this population could considerably raise their incomes if many physical and social barriers were removed.

1. A great many public programs of rehabilitation actually serve to foster dependence; many informants indicate that while the State, through the Medicaid program, is willing and able to support individuals in extensive care facilities at a cost of about $800 a month, they are unable to legally apply these funds to independent housing, university tuition and home health care even though this alternative would be both therapeutically superior and significantly less expensive for the tax payers.

2. Prejudice may be a factor affecting the availability of suitable employment for the disabled although more substantive study is needed to clarify this issue.

3. While intensified social programs would facilitate the normalization of the disabled, these efforts would be frustrated by countless physical barriers to integration; in our barrier free indealized P.U.D. all public and semi-public buildings would be constructed according to the following standards:

   a. at least one building entrance at ground level;
   b. 32" wide doors that open easily;
   c. level thresholds to buildings and rooms;
   d. sloping ramps instead of, or in addition to, stairs in a ratio of 1 to 12;
   e. safe parking for the handicapped close to buildings;
   f. level walks with no curbs at crossways;
   g. access by the disabled to elevators;
   h. restrooms with wide stalls and grab bars;
   i. handrails on all stairways extending beyond top and bottom steps;
   j. non-skid floors;
   k. lower fountains and public telephones (429).

4. Not only do the above architectural standards facilitate access by exceptional persons, they have significantly reduced accidents among the normal population (453).

C. Recommended Reading:

1. U.S.D.H.U.D. (417), annotated bibliography;
2. Goldsmith (423), designing for the disabled;
3. National Commission on Architectural Barriers (429), progress report;
4. U.S.D.H.U.D. (422), housing design;
5. Albert (447), travel and the disabled;
6. Cogen (456), comprehensive planning for the handicapped;
7. Dunn (465), report on pilot transportation project;
8. Fasteau (466), community college programs;
9. Wilson (509), barrier-free rapid transit;
10. Woodward (510), house design for paraplegics.

IV. CONSTRAINTS TO INNOVATION

A. Unfortunately, all of the numerous obstacles described in the preceding chapter would apply to efforts to improve the situation of the handicapped.

B. Added to these constraints is the heavily documented evidence of the deep seated prejudice of non-disabled individuals towards the handicapped; to make matters worse, it appears that attitudes toward the disabled are highly resistant to change regardless of the methods attempted (514, 518).

C. Recommended Reading:

1. Yuker (446), measurement of prejudice;
2. Corner (459), face-to-face interactions;
3. Jaques (478), cross cultural study;
4. Forader (514), modification of prejudice;
5. Jabin (520), relation of prejudice and personality types;
6. Granofsky (518), modification of prejudice.

RETARDED

I. CHARACTERISTICS OF THE MENTALLY RETARDED POPULATION

A. There exists no reliable census of our mentally retarded population.

1. Bernard Farber has estimated, on the basis of several samples from the United States and Europe, that between two and three percent of the population could be classified as being "mentally deficient" (551).

2. Only about one percent of the population, however, are actually known to be retarded by public and private agencies (569).

3. An estimated fifteen to twenty million people in the United States live in families in which there is a mentally retarded individual (569).

4. "In the absence of definitive surveys, perhaps the best statement regarding the prevalence of mental retardation which can be made at this time is that it is sufficiently greater than" the number of persons officially identified to "suggest that the continued demand and need for services will exceed the availability of such services for several years to come (569)."

B. Mental retardation can be defined as an inadequacy of general intellectual functioning which has existed from birth or childhood; while mental retardation is correlated with low scores on intelligence tests, "it is the deficiency in adaptive behavior and not a sub-average test score which draws society's attention to an individual (569)."

1. Test scores greater than one standard deviation below the mean (about IQ 84) indicate the possibility of retardation (569).

2. In actual practice, clinicians generally regard as retarded most persons having IQ's lower than two standard deviations below the mean (about IQ 70) (569).

3. Retardation varies in degree of severity; clinicians have identified four levels of impairment in adaptive behavior.

a. About 50% of all retardates are ridly impaired and, with proper preparation, can become fully capable of independent living and gainful employment (569).

b. Another 35% of the retarded population are moderately impaired adults who are capable of maintaining themselves in the community and performing adequately in unskilled work but who require some continuing supervision and assistance in adjusting to even the mild "social and econoric stresses in their lives" (569).

c. About 12% of the mentally retarded are considered capable of productive work activity but only under sheltered, non-competitive conditions (569).

d. Less than 4% of all retardates could be classified as being profoundly impaired and incapable of any significant activity and requiring intensive care and supervision (569).

4. Causes of Mental Retardation:

   a. Most severe and profound impairments are the result of some form of pathology of the central nervous system (569).

   b. A small number of persons may be retarded because of emotional or psychotic disorders occuring during childhood and interfering with normal learning processes (569).

   c. Some persons are impaired because of a secondary disability such as cerebral palsy (569).

   d. The greatest proportion of all retardates are those persons who appear normal but who function as mentally retarded (569).

   e. While types a, b, and c are generally distributed evenly throughout the population regardless of race, socioeconomic level, etc., the last - and most numerous - group is significantly more prevalent among economically and "culturally" deprived populations (569).

C. Recommended Reading:

1. Dickerson (462), retardation in the black community;
2. Adams (536), social aspects of retardation;
3. Allen (537), admissions to a residential facility;
4. Cobb (544), predicting adjustment of retarded;
5. Edgerton (549), stigma of the retarded;
6. Haywood (555), social-cultural aspects;
7. Mattinson (560), marriage and retardation;
8. Miller (562), longitudinal study of adjustment;
9. Morris (563), sociological study of institutions;
10. Sarason (567), psychological problems of retardates;
11. U.S.D.H.E.W. (577), patients in institutions;
12. Wendler (597), longitudinal study of adjustment;
13. Wolfensberger (599), family problems of the retarded.

II. EXISTING PROGRAMS AND FACILITIES

A. Residential facilities for the mentally retarded have traditionally been a national disgrace.

   1. Newspapers of several states periodically reveal atrocities which easily rival those of centuries past.

2. Public indignation has always been on the scene; it may now be possible, however, that we are making some truly substantive changes in our care of the institutionalized mentally retarded.

B. The concept of normalization is now firmly established within the professional community (439, 559, 796).

1. While the sterile, ultra large and hospital-like institutions are still favored by public operations, official policy rhetoric has adopted the normalization approach.

2. In many areas a definite system of decentralized residential and service facilities is emerging, albeit slowly.

3. A non-profit organization in Philadelphia currently operates four single family homes in which reside about twenty-four moderately to severely retarded adults supervised by full time house parents.

   a. The major concern of this organization has been the winning of total community acceptance; while they have been quite successful, they have also expended considerable energy.

   b. In spite of much professional expertise and the active support of many influential community leaders, the organization has had difficulty in obtaining mortgages on its properties.

4. The above innovations are enjoyed by only a tiny minority of institutionalized mentally retarded adults; the vast majority are still confined to the human warehouses of the traditional facilities.

5. Those mentally retarded adults able to live on their own do so as best they can with varying intensities and qualities of care from community agencies.

C. Recommended Reading:

1. Accreditation Council (535), facility standards;
2. Beck (540), social services for the retarded;
3. Blatt (542), public policy;
4. Commonwealth of Pennsylvania (546), state plan;
5. Elspeth (550), residential care facilities;
6. Kugel (559), recent trends in residential care;
7. Edgerton (620), public attitudes about institutions;
8. Kirkland (632), role of institutions;
9. Ragan (644), foster homes for retarded adults;

10. Rowland (650), new views on institutions;
11. Sindberg (654), legislation and public policy;
12. Solly (655), survey of services;
13. Wolfensberger (663), "Will there always be an institution?"

III. IDEALIZED MODELS OF OPTIMUM CARE

A. As in the case of the other groups of exceptional persons, adequate care for the mentally retarded is dependent on a wide range of physical facilities and human services including personal counseling, vocational training, transportation, housing and health care.

B. The planned community described in the first chapter would be an ideal environment for retarded persons of all degrees of disability.

1. The community would be fully integrated thus meeting the retarded person's need for normalization; it would also be self-contained thus providing security and convenience.

2. Those retarded individuals needing closer supervision could reside in the boarding home.

3. Many job opportunities could be made available in the community's maintenance crew, as aides in the boarding home and personal services (570) and as factory laborers through the addition of a small industrial park.

4. If the proper balance could be maintained in the composition of the community's resident population, the needs of both the exceptional person and his family could be satisfied to an equal degree.

C. Recommended Reading:

1. U.S.D.H.E.W. (439), transfer of patients from institution to community based residences;
2. Clark (543), transitional program of residential care;
3. Meyen (561), planning community services;
4. N.A.R.C. (564), architectural programming;
5. U.S.D.H.E.W. (578), facility planning;
6. U.S.D.H.E.W. (580), activity centers;
7. President's Committee (584), residential services;
8. U.S.D.H.E.W. (585), transportation;
9. Wolfensberger (600, 796), specialized group housing;
10. Soder (656), housing integration;
11. Sternlight (658), housing integration;
12. White (661), day care services.

IV. CONSTRAINTS TO INNOVATION

A. Poor coordination among the many social services needed to adequately serve the non-institutionalized retarded adult.

B. Bureaucratic preferences for centralized management and standardized facilities.

C. Procrastination by legislators.

D. Community prejudice toward the retarded persons.

E. General dislike of "balanced communities.

EPILOG

It is sometimes advisable to approach a problem by first dividing it into its component parts and then dealing with each separately. Frequently, when there are many actors, the pieces become so small and are so widely scattered that any sense of the whole must be left to memory.

While the aged, the handicapped and the mentally retarded have very similar problems in regard to the larger community, each group has its own constituent professional groups with disparate perspectives. While the medical labels are helpful to the physician, they hinder the planner who must only use categories which are relevant to his own purposes. Accordingly, the differences among the three types of exceptional persons examined here disappear to be replaced by levels of dependency. Suddenly the task of designing community facilities is less complex and more responsive to individual needs.

The preceding chapters were hastily constructed to illustrate the above approach; if the reader is looking for truth, he will have to struggle with the literature cited in the following sections and find it for himself.

SOURCES

ASSOCIATIONS

AGED

American Association of homes for the Aging; 374 National Press Building, Washington, D. C. 20004; EXECUTIVE DIRECTOR: Frank G. Zelenka; PHONE: 202-347-2000; MEMBERS: 1000; STAFF: 6.

PUBLICATIONS:
1) Executive Memo, monthly;
2) News Scene, monthly;
3) Directory of Non-Profit Homes for the Aged, 1962;
4) AAHA Action Bulletin;
5) Directions Series;
6) Social Components of Care.

FUNCTIONS: Liason with government in curriculum development for home administrators; conducts training for home personnel.

American Baptist Homes & Hospitals Association; Valley Forge, Pennsylvania 19481; EXECUTIVE DIRECTOR: Rev. Ray L. Schroder; PHONE: -; MEMBERS: 550; STAFF: -.

PUBLICATIONS: Concern, bimonthly.

FUNCTIONS: Formed to encourage the cooperation of Baptist church-related institutions.

American College of Nursing Home Administrators; 8641 Colesville Rd., Suite 409, Silver Spring, Maryland 20910; EXECUTIVE DIRECTOR: Lynn W. Morris; PHONE: 301-589-9070; MEMBERS: 3000; STAFF: 7.

PUBLICATIONS: 1) Newsletter, monthly;
2) Staff Notes, monthly;
3) Journal, semiannually;
4) Bulletin, irregular.

FUNCTIONS: Works to elevate standards of nursing home administrators; encourages research in geriatrics and administration; certifies as to members' competence.

American Nursing Home Association; 1025 Connecticut Ave., N.W., Suite 607, Washington, D. C.; EXECUTIVE DIRECTOR: C. Robert Harberson; PHONE: 202-296-5636; MEMBERS: 7500; STAFF: -.

PUBLICATIONS: 1) ANHA Newsletter, monthly;
2) Nursing Homes, monthly.

FUNCTIONS: Prepares annual compilation nursing homes, bed totals, and welfare payments, by State.

Central Bureau for the Jewish Aged; 31 Union Square West, New York, New York 10003; EXECUTIVE DIRECTOR: John J. Kapeles; PHONE: 212-WA. 4-5454; MEMBERS: 55; STAFF: -.

PUBLICATIONS: News and Views.

FUNCTIONS: Coordinates study of care for the aged; attempts to improve and expand Welfare facilities for the aged.

Golden Ring Council of Senior Citizen Clubs; 22 W. 38th St., New York, New York 10018; EXECUTIVE DIRECTOR: Moe Diamond; PHONE: 212-947-2019; MEMBERS: 50 Clubs; STAFF: -.

PUBLICATIONS: Senior Citizens Reporter, quarterly.

FUNCTIONS: Promotes better living conditions, social activities, and legislation for the aged.

International Senior Citizens Associations; 11753 Wilshire Blvd., Los Angeles, California 90025; EXECUTIVE DIRECTOR: Mrs. Marjorie Borchardt; PHONE: -; MEMBERS: -; STAFF: -.

PUBLICATIONS: ISCA Newsletter, quarterly.

FUNCTIONS: Provides coordination at international level to safeguard interests and needs of the aged.

Lutheran Hospitals & Homes Society; 70 North 5th Street, Fargo, North Dakota 58102; EXECUTIVE DIRECTOR: H. H. Malm; PHONE: 701-232-2527; MEMBERS: 18,000; STAFF: -.

PUBLICATIONS: -.

FUNCTIONS: Maintain general hospitals, homes for the aged, and nursing care homes.

National Association for the Advancement of Older People; 30175 Ford Rd., Garden City, Michigan 48135; EXECUTIVE DIRECTOR: Joseph Stackable; PHONE: 313-261-5260; MEMBERS: -; STAFF: -.

PUBLICATIONS: -.

FUNCTIONS: Association of older people who promote opportunities for the elderly; encourage building of nursing homes to fit modern needs.

National Association of Jewish Homes for the Aged; 2525 Centerville Rd., Dallas, Texas 75228; EXECUTIVE DIRECTOR: Dr. Herbert Shore, V. Pres.; PHONE: 214-DA. 7-4503; MEMBERS: 100; STAFF: -.

PUBLICATIONS: 1) Progress Report, quarterly;
2) Directory, biennial.

FUNCTIONS: Conducts institutes; undertakes legislative activities; compiles statistics.

National Council of Senior Citizens; 1627 K Street, N.W., Washington, D. C. 20006; EXECUTIVE DIRECTOR: William Hutton, V. Pres.; PHONE: 202-783-6850; MEMBERS: 3000; STAFF: 30.

PUBLICATIONS: Senior Citizens News, monthly.

FUNCTIONS: Educational and action group which works in behalf of issues and programs for the elderly.

National Council on the Aging; 1828 L Street, N.W., Washington, D. C. 20036; EXECUTIVE DIRECTOR: William C. Fitch; PHONE: 202-223-6250; MEMBERS: 1400; STAFF: 80.

PUBLICATIONS: 1) Legislative Supplement, monthly;
2) Senior Opportunities and Services, monthly;
3) NCOA Reports, bimonthly;
4) Current Literature on Aging, quarterly.

FUNCTIONS: Provides information and consultation service; holds conferences and workshops; conducts research and demonstration projects on problems of the elderly.

New England Project on Education of the Aging; Program in Gerontology, University of Rhode Island, Kingston, Rhode Island 02881; EXECUTIVE DIRECTOR: Muriel B. Wilbur; PHONE: 407-792-2440; MEMBERS: -; STAFF: 3.

PUBLICATIONS: Education of the Aging, monthly.

FUNCTIONS: Founded to increase the number of people involved in education of the aging, to identify educators, and to increase the body of knowledge on aging.

The Gray Panthers; c/o Tabernacle Church, 3700 Chestnut Street, Philadelphia, Pennsylvania 19104; EXECUTIVE DIRECTOR: Margaret E. Kuhn; PHONE: 215-387-4100; MEMBERS: 1000; STAFF: 2.

PUBLICATIONS: -.

FUNCTIONS: Growing national organization with several local chapters (primarily in the Northeastern U.S.). Liberally-orientated activist Lobby for more "people-serving programs," and the elimination of arbitrary barriers to self-actualization.

Vacations for the Aging; 225 Park Avenue, South, New York, New York 10003; EXECUTIVE DIRECTOR: Mrs. Whitehouse Walker; PHONE: 212-777-5000; MEMBERS: -; STAFF: -.

PUBLICATIONS: -.

FUNCTIONS: Raises funds to subsidize camps that serve the elderly and to finance the costs of the elderly attending. The organization sends more than 3000 elderly to camps a year.

HANDICAPPED

American Academy for Cerebral Palsy; c/o Harold B. Levy, M.D., 6300 Line Avenue, Shreveport, Louisiana 71106. EXECUTIVE DIRECTOR: Harold B. Levy, M.D., Secretary; PHONE: 318-865-5623; MEMBERS: 624; STAFF: -.

PUBLICATIONS: Journal of Developmental Medicine and Child Neurology, 6/yr.

FUNCTIONS: Association of professionals interested in care, treatment, and research; makes awards and grants.

American Association of Workers for the Blind; 1511 K Street, N.W., Suite 637, Washington, D. C. 20005; EXECUTIVE DIRECTOR: John L. Naler; PHONE: 202-347-1559; MEMBERS: 2700; STAFF: 5.

PUBLICATIONS: 1) A.A.W.B. News & Views, bimonthly;
2) Blindness, annual;
3) Convention Proceedings, biennial.

FUNCTIONS: Individuals and agencies interested in the welfare of the blind and the prevention of blindness.

American Epilepsy Society; Division of Neurology, College of Medicine, University of Florida, Gainesville, Florida 32601; EXECUTIVE DIRECTOR: -; PHONE: 904-376-1611, Ext. 307; MEMBERS: 550; STAFF: -.

PUBLICATIONS: Epilepsia, quarterly.

FUNCTIONS: Association of physicians; fosters research and treatment of epilepsy.

American Rehabilitation Committee; 28 East 21st Street, New York, New York 10010; EXECUTIVE DIRECTOR: Frederic G. Elton; PHONE: 212-GR. 5-0255; MEMBERS: 800; STAFF: 9.

PUBLICATIONS: Rehabilitation Review Bulletin, bimonthly.

FUNCTIONS: Operates rehabilitation center.

American Rehabilitation Foundation; 1800 Chicago Avenue, Minneapolis, Minnesota 55402; EXECUTIVE DIRECTOR: Paul N. Ellwood, Jr., M.D.; PHONE: 612-333-4251; MEMBERS: -; STAFF: 360.

PUBLICATIONS: -.

FUNCTIONS: Sponsors Kenny Rehabilitation Institute; conducts research; plans to expand rehabilitation facilities, in U.S.

Commission on the Accreditation of Rehabilitation Facilities; 645 N. Michigan Avenue, Chicago, Illinois 60611; EXECUTIVE DIRECTOR: Alan H. Toppel; PHONE: 312-642-6061; MEMBERS: -; STAFF: 4, plus 60 Survey Consultants.

PUBLICATIONS: 1) CARF Report, quarterly;
2) List of Accredited Facilities, quarterly;
3) Standards Manual for Rehabilitation Facilities.

FUNCTIONS: Surveys and accredits rehabilitation facilities; conducts research related to standards.

Disabled American Veterans; 3725 Alexandria Pike, Cold Spring, Kentucky 41076; EXECUTIVE DIRECTOR: Denvel D. Adams, National Adjutant; PHONE: 606-441-7300; MEMBERS: 302,000; STAFF: 140.

PUBLICATIONS: DAV Magazine, monthly.

FUNCTIONS: Association of veterans; major activity is sale of miniature license plates; awards scholarships.

Disabled American Veterans Auxiliary; 3725 Alexandria Pike, Cold Spring, Kentucky 41076; EXECUTIVE DIRECTOR: L. Kit Seal, National Adjutant; PHONE: 606-441-7300; MEMBERS: 40,000; STAFF: -.

PUBLICATIONS: DAV Auxiliary Magazine, monthly.

FUNCTIONS: Serves veterans and their dependents.

Disabled Officers Association; 1612 K Street, N.W., Suite 408, Washington, D.C. 20006; EXECUTIVE DIRECTOR: Walter J. Reilly; PHONE: 202-347-3401; MEMBERS: 6000; STAFF: 3.

PUBLICATIONS: Bulletin, 9/yr.

FUNCTIONS: Provides services to disabled officers.

Epilepsy Foundation of America; 733 15th Street, N.W., Washington, D.C. 20005; EXECUTIVE DIRECTOR: Paul E. Funk; PHONE: 202-638-4350; MEMBERS: -; STAFF: -.

PUBLICATIONS: 1) Candlelight, monthly;
2) National Spokesman, quarterly;
3) PAB News, quarterly.

FUNCTIONS: Sponsors research and workshops; provides student grants; counsels epileptics.

Human Resources Center; I. U. Willets Rd., Albertson, New York 11507; EXECUTIVE DIRECTOR: Frank D. Gentile, V. Pres.; PHONE: 516-747-2700; MEMBERS: -; STAFF: 325 permanent; 100 volunteers.

PUBLICATIONS: Reprints, studies, monographs.

FUNCTIONS: Center for vocational rehabilitation and special education for the handicapped; provides training; conducts research.

International Association of Rehabilitation Facilities; 7979 Old Georgetown Rd., Washington, D.C. 20014; EXECUTIVE DIRECTOR: Charles L. Roberts; PHONE: 301-654-5882; MEMBERS: 650; STAFF: 13.

PUBLICATIONS: -.

FUNCTIONS: Promotes expansion of services to the disabled; sponsors workshops; is establishing standards for rehabilitation centers and facilities; with other groups has prepared a guide for architects.

International Society for Rehabilitation of the Disabled; 219 E. 44th Street, New York, New York 10017; EXECUTIVE DIRECTOR: Norman Acton; PHONE: 212-986-1470; MEMBERS: 63; STAFF: -.

PUBLICATIONS: 1) International Rehabilitation Review, quarterly;
2) Prosthetics International, irregular;
3) Directory of Member Organizations, annually.

FUNCTIONS: Clearinghouse for world distribution of rehabilitation literature; encourages international fellowships; assists students in planning work and study programs.

National Accreditation Council for Agencies Serving the Blind and Visually Handicapped; 79 Madison Avenue, Suite 1406, New York, New York 10016; EXECUTIVE DIRECTOR: Alexander F. Handel; PHONE: 212-683-8581; MEMBERS: 33; STAFF: 10.

PUBLICATIONS: 1) Standard Bearer, 3/year;
2) List of accredited agencies and schools for the visually handicapped.

FUNCTIONS: Administers voluntary system of accreditation.

National Association of the Physically Handicapped; 6473 Grandville, Detroit, Michigan 48228; EXECUTIVE DIRECTOR: Marlow W. Munns; PHONE: 313-271-0160; MEMBERS: 900; STAFF: -.

PUBLICATIONS: NAPH National Newsletter, quarterly.

FUNCTIONS: Promotes employment opportunities; makes awards for service to and employment of the handicapped.

National Congress of Organizations of the Physically Handicapped; 7611 Oakland Avenue, Minneapolis, Minnesota 55423; EXECUTIVE DIRECTOR: Elmer Josephs; PHONE: 612-861-2162; MEMBERS: 200; STAFF: 1.

PUBLICATIONS: 1) COPH Bulletin, quarterly;
2) Roster of Organizations, annually;
3) Roster of Publications, annually;

FUNCTIONS: Assists member organizations with programs; clearinghouse for literature by and about the handicapped.

National Easter Seal Society for Crippled Children and Adults; 2023 W. Ogden Avenue, Chicago, Illinois 60612; EXECUTIVE DIRECTOR: Jayne Shover; PHONE: 312-243-8400; MEMBERS: 52 State Groups/1400 Local Groups; STAFF: -.

PUBLICATIONS: 1) Rehabilitation Literature, monthly;
2) Easter Seal Bulletin, semiannual.

FUNCTIONS: Establishes and conducts programs for the handicapped; disseminates information on needs and services.

National Order of Trench Rats; 1333 N. Kenter Avenue, Los Angeles, California 90049; EXECUTIVE DIRECTOR: J. Earl Merifield; PHONE: 213-472-2624; MEMBERS: 3100; STAFF: 2.

PUBLICATIONS: Bulletin, 5/year.

FUNCTIONS: Fraternal organization of disabled veterans; supports legislation; participates in civic and charitable activities.

National Paraplegia Foundation; 333 N. Michigan Avenue, Chicago, Illinois 60601; EXECUTIVE DIRECTOR: James Smittkamp; PHONE: 312-346-4779; MEMBERS: 2500; STAFF: 3.

PUBLICATIONS: The Squeaky Wheel, bimonthly.

FUNCTIONS: Informs and educates medical profession and public on paraplegia; makes grants for research.

National Rehabilitation Association; 1522 K Street, N.W., Washington, D.C. 20005; EXECUTIVE DIRECTOR: E. B. Whitten; PHONE: 202-649-2430; MEMBERS: 32,000; STAFF: 24.

PUBLICATIONS:
1) Journal of Rehabilitation, bimonthly;
2) NRA Newsletter, bimonthly;
3) Legislative Newsletter, 3-4 year.

FUNCTIONS: Association of professionals and others interested in rehabilitation.

Paralyzed Veterans of America; 3636 16th Street, Washington, D.C. 20010; EXECUTIVE DIRECTOR: Michael W. Burns; PHONE: 202-387-4717; MEMBERS: 8000; STAFF: -.

PUBLICATIONS:
1) Paraplegia News, monthly;
2) other material on paraplegia, booklets, leaflets.

FUNCTIONS: Promotes sports and employment programs for paraplegics; promotes for paraplegics; promotes legislation to create public housing for paraplegics.

United Cerebral Palsy Association; 66 East 34th Street, New York, New York 10016; EXECUTIVE DIRECTOR: Earl H. Cunnerd; PHONE: 212-889-6655; MEMBERS: 350; STAFF: 90.

PUBLICATIONS: UCP Crusader, bimonthly.

FUNCTIONS: Provides treatment and therapy; conducts training; maintains recreational facilities; provides counselling for parents.

World Rehabilitation Fund; 400 East 34th Street, New York, New York 10016; EXECUTIVE DIRECTOR: Eugene J. Taylor, Secretary; PHONE: 212-OR9-3200; MEMBERS: 31; STAFF: 6.

PUBLICATIONS: -.

FUNCTIONS: Supports development of services for the handicapped; provides fellowships for physicians from abroad for advanced training in rehabilitation medicine; conducts training throughout the world.

RETARDED

American Academy on Mental Retardation; Developmental Center, Maimonides Medical Center, 4802 Tenth Avenue, Brooklyn, New York 11219; EXECUTIVE DIRECTOR: James D. Block, Secretary; PHONE: -; MEMBERS: 126; STAFF: -.

PUBLICATIONS: -.

FUNCTIONS: Association of scientists; promotes research.

Association for Children with Retarded Mental Development; 114 West 30th Street, New York, New York 10010; EXECUTIVE DIRECTOR: Ida Rappaport; PHONE: 212-564-7430; MEMBERS: 4000; STAFF: 12.

PUBLICATIONS: 1) A/CRMD on the Record, monthly;
2) Mandate, quarterly;
3) Directory, annually.

FUNCTIONS: Offers programs for the mentally retarded, including rehabilitation, recreation, and day care centers, counselling, job training, and placement.

American Association on Mental Deficiency; 5201 Connecticut, N.W., Washington, D.C. 20015; EXECUTIVE DIRECTOR: George Soloyanis; PHONE: 202-244-8143; MEMBERS: 9400; STAFF: 10.

PUBLICATIONS: 1) American Journal of Mental Deficiency, bimonthly;
2) Mental Retardation, bimonthly;
3) Directory of Members, biennial;
4) Directory of Residential Facilities.

FUNCTIONS: Association of professionals and others interested in the study of cause, treatment and prevention of mental retardation.

Educational Guidance Center for the Mentally Retarded; 441-5 West 47th Street, New York, New York 10036; EXECUTIVE DIRECTOR: Phillip Davis; PHONE: 212-247-6363; MEMBERS: 10; STAFF: 11.

PUBLICATIONS: -.

FUNCTIONS: Association of professionals; sponsors vocational training, recreational, social and cultural activities; is constructing an apartment complex for 200 employable retarded adults.

National Association for Retarded Children; 2709 E, East, Arlington, Texas 76112; EXECUTIVE DIRECTOR: Philip Roos; PHONE: 817-261-4961; MEMBERS: 200,000; STAFF: 50.

PUBLICATIONS: Mental Retardation News, 10/year.

FUNCTIONS: Promotes treatment, research, public understanding and legislation for the mentally retarded.

National Association of Coordinators of State Programs for the Mentally Retarded; 2001 Jefferson Davis Highway, Suite 802; EXECUTIVE DIRECTOR: Robert M. Gettings; PHONE: 703-920-0770; MEMBERS: 53; STAFF: -.

PUBLICATIONS: 1) New Directions, monthly;
2) Capitol Capsul, irregular;
3) State Capitol Capsule, irregular.

FUNCTIONS: Association of state administrative personnel working with programs for the mentally retarded.

Retarded Infants Services; 386 Park Avenue, South, New York, New York 10016; EXECUTIVE DIRECTOR: Mrs. Newton S. Arnold; PHONE: 212-889-5464; MEMBERS: -; STAFF: 18.

PUBLICATIONS: Retarded Infants Services News, annually.

FUNCTIONS: Assists families with interim placement of infants and/or home-aid services; offers counselling and provides financial grants to families. Sponsors legislation; initiated a program to train non-professional women as home-aides.

OTHER

Association for Middle Income Housing; 217 Park Row, New York, New York 10038; EXECUTIVE DIRECTOR: -; PHONE: -; MEMBER: 7000; STAFF: 2.

PUBLICATIONS: AMIH Newsletter, quarterly.

FUNCTIONS: Promotes middle income housing; aids in formation of housing cooperatives; collects data on members' housing preferences; maintains a 700 volume library.

Foundation for Cooperative Housing; 1012 14th Street, N.W., Washington, D.C. 20005; EXECUTIVE DIRECTOR: Wallace J. Campbell; PHONE: 202-737-3411; MEMBERS: -; STAFF: 325.

PUBLICATIONS: F.C.H. News Briefs, monthly.

FUNCTIONS: Encourages cooperative housing and research; as of 1971, 400 coops with 48,000 d.u.! Also manages coop housing; supported by fees of member coopers; heavy overseas work.

Institute of Human-Animal Relationship; 1629 K Street, N.W. Washington, D.C. 20006; EXECUTIVE DIRECTOR: Dr. Dean White; PHONE: 202-296-8273; MEMBERS: 2500; STAFF: -.

PUBLICATIONS: 1) Pet Digest, quarterly;
2) Human-Animal Relationship (directory), quarterly.

FUNCTIONS: Aids geriatric patients, shut-ins, and emotionally and physically handicapped children and adults by giving them a pet, pet supplies and training; maintains library.

National Association of Housing and Redevelopment Officials (NAHRO); 2600 Virginia Avenue, N.W., Washington, D.C. 20037; EXECUTIVE DIRECTOR: Robert W. Maffin; PHONE: 202-333-2020; MEMBERS: 8700; STAFF: 38.

PUBLICATIONS: 1) Newsletter, weekly;
2) Journal of Housing, monthly.

FUNCTIONS: Organization of individuals and agencies engaged in large scale housing programs.

National Committee Against Discrimination in Housing; 1865 Broadway, New York, New York 10023; EXECUTIVE DIRECTOR: Edward Rutledge and Jack E. Wood; PHONE: 212-265-2780; MEMBERS: 98; STAFF: 29.

PUBLICATIONS: Trends in Housing, 8/year.

FUNCTIONS: Affliation of 47 national organizations, serves as center for public information; currently, no activities explicitly for "exceptional persons."

National Council of Homemaker-Home Health Aides; 1740 Broadway, New York, New York 10019; EXECUTIVE DIRECTOR: Mrs. Florence Moore; PHONE: 212-C15-8000; MEMBERS: 580; STAFF: 6.

PUBLICATIONS: 1) News, 5/year;
2) Directory of Homemaker Home Health Aide Services, every 2-3 years;
3) Conference reports and standards.

FUNCTIONS: Offers lending library for communities; distributes educational and promotional materials; guides communities in organizing and extending homemaker services.

FOUNDATIONS

Ford Foundation; Office of Reports; 477 Madison Avenue, New York, New York 10022.

Forest Park Foundation; 4801 North Prospect Road, Peoria Heights, Illinois 61614; Robert B. Rutherford, M.D., President.

Financial Data, June 1969:
Assets: $6,866,372
Gifts: $ 113,102
Expenditures: $ 645,324; 18 grants
Sponsors research in gerontology; serves handicapped of all ages in its Institute of Physical Medicine and Rehabilitation; grants awarded for pilot programs in home care, geriatric rehabilitation and the training of nursing home operators.

Frueauff Foundation, Incorporated; 70 Pine Street, New York, New York 10005.

Particular interest in health services for the handicapped; grants for purchase of buildings and equipment.

Given Foundation; One Wall Street, Room 2400, New York, New York 10005.

Financial Data, April 1970:
Assets: $2,375,752
Gifts: $ 193,223
Expenditures: $5,335,623; 34 grants
Medical research, education and rehabilitation of the handicapped.

Kresge Foundation, Incorporated; 1500 North Woodward Avenue, Birmingham, Michigan 48011; William H. Bladwin, President.

Financial Data, December 1969:
Assets: $432,580,144
Expenditures: $ 8,999,068; 170 grants.
Grants for building construction and the purchase of major equipment to institutions in higher education, hospitals and health related services and organizations involved in the care of youth and the aged.

Rockefeller Brothers Fund; 30 Rockefeller Plaza, New York, New York 10020; Dana S. Creel, President.

Financial Data, December 1969:
Assets: $198,175,471
Gifts: $ 103,700
Expenditures: $ 8,981,471; 213 grants
Broad interests.

Scott Foundation; 24 East Parkway, Scarsdale, New York 10583; Joseph A. Nickerson, President and Treasurer.

Financial Data, September 1970:
Assets: $2,301,046
Expenditures: $ 93,938; 46 grants
Aid to handicapped children.

Weinburger Foundation; New York, New York

Sponsors innovative pilot program involving the relocation of severly handicapped persons into private apartments where they live with a minimum of supervision; they have reportedly been quite successful in "normalizing" this sample of exceptional persons.

FEDERAL AGENCIES

The following lists of federal agencies and their responsibilities in regard to exceptional persons were derived from the July, 1972 edition of the United States Government Organization Manual.

These lists were not intended to be used as directories but to simply indicate the extent and diversity of the federal government's involvement in assisting exceptional persons.

AGED

ACTION

Foster Grandparents. Offers opportunities for older persons to work closely with institutionalized children.

Retired Senior Volunteers. Provides opportunities for older persons to serve as volunteers in many community service projects.

Service Corps of Retired Executives. Offers opportunities for retired persons with successful career experience to share their expertise with small businessmen.

AGRICULTURE

Marketing and Consumer Services, Food and Nutrition Service. Provides food assistance through food stamps to needy persons, including the aged.

Rural Development and Conservation, Farmers Home Administration. Makes housing loans available to persons 62 and over living in rural areas and needing housing specially suited to their needs.

Rural Development and Conservation, Forest Service. Provides special manpower training for disadvantaged, rural aged.

HEALTH, EDUCATION AND WELFARE

Health Services and Mental Health Administration, Community Health Services. Promotes quality of health care for the elderly.

Health Services and Mental Health Administration, Health Care Facilities Service. Administers grants and loans for health facilities.

Health Services and Mental Health Administration, National Institute of Mental Health. Conducts and funds geriatric research.

Health Services and Mental Health Administration, National Center for Health Services Research and Development. Conducts and supports research on community based health systems.

Office of Education, Bureau of Adult, Vocational and Technical Education. Administers grants to states for adult education.

Office of Education, Bureau of Libraries and Learning Resources. Administers library services for the aging.

Social and Rehabilitation Service, Assistance Payments Administration. Delivers grants to states for provision of old age assistance to needy aged.

Social and Rehabilitation Service, Medical Services Administration. Administers Medicaid program.

Social Security Administration, Bureau of Health Insurance. Administers Medicare program, develops standards for hospitals, nursing homes and home health agencies.

Social Security Administration, Bureau of Retirement and Survivors Insurance. Administers pension program for elderly.

HOUSING AND URBAN DEVELOPMENT

Assistant Secretary for Housing and Mortgage Credit. Provides mortgage insurance for skilled nursing homes, intermediate care facilities and hospitals. Provides mortgage insurance for housing for the elderly. Administers 236 rent subsidy and public housing programs.

OFFICE OF ECONOMIC OPPORTUNITY

Legal Services. Conducts (conducted ?) research on the legal problems of the elderly.

PRESIDENT'S COUNCIL ON AGING

Reviews and coordinates federal activities regarding the aged.

RAILROAD RETIREMENT BOARD

Provides retirement benefits to former railroad employees and their families.

TRANSPORTATION

Federal Highway Administration. Encourages states to design rest areas and tourist facilities for the aged; has funded studies of the transportation problems of the urban elderly.

Urban Mass Transportation Administration. Assists state and local agencies in providing mass transportation for the elderly.

VETERANS ADMINISTRATION

Department of Veterans Benefits, Compensation and Pension Service. Administers veterans pensions.

Field Stations. Provide general medical and psychiatric hospital care, nursing home care and sponsor program of home care for eligible veterans.

HEALTH, EDUCATION AND WELFARE

Office of the Secretary, Administration on Aging (effective April 1973). Delivers grants to states for development of services and opportunities for the aged.

HANDICAPPED

ACTION

Foster Grandparents. Older volunteers assisting handicapped in institutions.

AMERICAN PRINTING HOUSE FOR THE BLIND

Assists in the education of the blind.

COMMITTEE FOR THE PURCHASE OF PRODUCTS AND SERVICES OF THE BLIND AND OTHER SEVERELY HANDICAPPED

Determines suitability and price of all goods and services offered for sale to the Federal Government by agencies for the blind and handicapped.

GALLAUDET COLLEGE

Provides higher education for the deaf.

HEALTH, EDUCATION AND WELFARE

Health Services and Mental Health Administration, National Center for Health Services Research and Development. Conducts and supports research on community based health services.

Office of Education, Bureau of Education for the Handicapped. Assists schools, institutions and agencies in meeting educational needs of handicapped children.

Social and Rehabilitation Service, Assistance Payments Administration. Delivers grants to states for income maintenance payments to needy persons, including the blind and the permanently and totally disabled.

Social and Rehabilitation Service, Medical Services Administration. Delivers grants to states for payment of medical care for the needy (Medicaid), including the permanently and totally disabled.

Social and Rehabilitation Service, Rehabilitation Services Administration. Provides grants to states for rehabilitation of persons permanently and totally disabled.

LABOR

Manpower Administration, U.S. Employment Service. Cooperates in the employment placement of disabled veterans.

LIBRARY OF CONGRESS

Division for the Blind and Physically Handicapped. Provides books in raised braille, in type and on records and tapes for the blind and handicapped operating through 51 regional libraries.

PRESIDENT's COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED

Facilitates development of employment opportunities for the handicapped.

TRANSPORTATION

Urban Mass Transportation Administration. Assists state and local agencies in providing mass transportation for the handicapped.

U.S. CIVIL SERVICE COMMISSION

Bureau of Recruiting and Examining. Assists in the selective placement of the physically handicapped in federal agencies.

VETERANS ADMINISTRATION

Department of Veterans Benefits, Compensation and Pension Service. Administers disability compensation pensions.

Department of Veterans Benefits, Education and Rehabilitation Service. Reviews claims for vocational rehabilitation of disabled veterans and for educational assistance to veterans, including the disabled.

Field Stations. General medical, psychiatric and home care.

RETARDED

ACTION

Foster Grandparents. Aged volunteers working in institutions for the mentally retarded.

HEALTH, EDUCATION AND WELFARE

Health Services and Mental Health Administration, Health Care Facilities Service., Administers grants and loans for facilities for the mentally retarded.

Health Services and Mental Health Administration, National Center for Health Services Research and Development. Conducts and supports research on community based health services.

Office of the Secretary, Office of Mental Retardation Coordination. Provides information on H.E.W. programs for the retarded.

Social and Rehabilitation Service, Assistance Payments Administration. Delivers grants to states for income maintenance programs for the needy, including the developmentally disabled.

Social and Rehabilitation Service, Medical Services Administration. Delivers grants to states for Medicaid payments to the needy, including the developmentally disabled.

Social and Rehabilitation Service, Rehabilitation Services Administration. Provides grants to states for the rehabilitation of the developmentally disabled.

PRESIDENT's COMMITTEE ON MENTAL RETARDATION

Advises President on mental retardation policy.

U.S. CIVIL SERVICE COMMISSION

Bureau of Recruiting and Examining. Assists in the selective placement of some developmentally disabled persons in federal agencies.

RESEARCH INSTITUTIONS

Allen Memorial Institute of Psychiatry; McGill University; 1025 Pine Avenue, Montreal 112, Quebec, Canada; 514-842-1251; Dr. R. A. Cleghorn.

Geriatric aspects of biochemistry, endocrinology, and neurophysiology.

Arkansas Rehabilitation Research and Training Center; University of Arkansas; Fayetteville, Arkansas 72701; Dr. Vernon L. Glenn.

Bureau of Public Health Research; University of Oklahoma, 800 Northeast 13th Street, Oklahoma City, Oklahoma 73104; 405-236-1366; Dr. Wilson Steen; 1963 27.

Health care delivery systems.

Bureau of Research and Community Services; University of Alabama, Birmingham; 1919 Seventh Avenue, South, Birmingham, Alabama 35233; 205-934-4634; Dr. Charles L. Joiner; 1967 14.

Public health planning.

Center for Chronic Disease; New York Medical College; Bird S. Coler Hospital; New York, New York 10017; 212-688-9400; Dr. Milton Lowenthal; 1964 --.

Chronic diseases, rehabilitation, and geriatric care.

Center for Comprehensive Health Planning; University of Virginia; Center for Comprehensive Health Planning; Charlottesville, Virginia 22903; Dr. C. M. Kanin; 1971.

Center for Death Education and Research; 1167 Social Science Building; Minneapolis, Minnesota 55455; 612-373-3686; Dr. Robert Fulton; 1969 4.

Attitudes and responses to death and dying.

Center for Health Administration Studies. University of Chicago; 5720 Woodlawn Avenue, Chicago, Illinois 60637; 312-643-0800; George Busbee; 1962 25.

Social and economic aspects in the delivery of medical care.

Center for Housing and Environmental Studies; Cornell University; Ithaca, New York 14850.

Has conducted several studies on designing environments for the aged.

Center for Human Growth and Development; University of Michigan; 611 Church Street, Ann Arbor, Michigan 48104; 313-764-4485; Dr. Robert E. Moyers; 1964 78.

Developmental biology.

Center for Social Research in Rehabilitation Medicine; Albert Einstein College of Medicine; Morris Park Avenue & East Chester Road, Bronx, New York 10461; 212-430-2288; Dr. Bernard Kutner; 1964 6.

Anthropological, sociological, psychological concepts relevant to rehabilitation medicine and disability; institutional management and community organization.

Center for the Study of Aging and Human Development; Duke University, Medical Center; Durham, North Carolina 27706; 919-684-8111; Dr. Ewald W. Busse; 1957.

Gerontology: physiological, psychological and socio-economic aspects of aging.

Center for the Study of Mental Retardation; University of Alberta; Edmonton 7, Alberta, Canada; 403-432-4439; Dr. Donald R. Cameron.

Medical aspects of retardation, demonstration educational programs.

Center on Behavioral Disabilities; University of Wisconsin; 2570 University Avenue, Madison, Wisconsin 53706; 1964 34.

Psychological aspects of mental retardation.

Deafness Rehabilitation Research and Training Center; New York University; 80 Washington Square, New York, N.Y. 10003; Dr. Jerome D. Schein.

Eastern Pennsylvania Psychiatric Institute; Henry Avenue and Abbottsford Road, Philadelphia, Pennsylvania 19129; 215-848-6000; Dr. William A. Philips; 1949 81.

Mental illness and mental retardation, administration of mental disability in Commonwealth of Pennsylvania.

Family Service Center; Syracuse University; 300 Burt Street, Syracuse, New York 13202; 315-475-0144; Harry Thompson; 1963 34.

Education, social services, health programs for poor and elderly in urban areas.

Gerontology Center; University of Southern California; University Park; Los Angeles, California 90007; 213-746-6060; Dr. James E. Birren; 1964 27.

Biological, behavioral, social and environmental aspects of aging; coordination of research in architecture, urban planning, public administration and other fields.

Human Resources Center; I. U. Willets Road; Albertson, New York 11507; 516-747-2700; Harry Viscardi, Jr.; 1952 55.

Vocational rehabilitation and special education of physically and mentally handicapped children and adults; problems of homebound aged.

Institute for Chronic Diseases and Rehabilitation; University of California at Los Angeles; Los Angeles, California 90024; 213-825-5381; Dr. Ralph Goldman; 1965 202.

Rehabilitation medicine.

Institute for Crippled and Disabled; New York University; 340 East 24th Street, New York, New York 10010; 212-679-0100; 1917 33.

Basic medical studies in causes of disability and methods of rehabilitation.

Institute for the Study of Mental Retardation; University of Michigan; 611 Church Street, Ann Arbor, Michigan 48104; 313-763-3171; Dr. William M. Cruickshank; 1966 23.

Interdisciplinary training of professionals for work with retarded.

Institute of Gerontology; University of Iowa; 26 Byington Road, Iowa City, Iowa 52240; 319-353-5010; Dr. W. W. Morris; 1952 12.

Educational, family, marital and psychological aspects of aging.

Institute of Gerontology; University of Michigan; 1021 East Huron Street, Ann Arbor, Michigan 48104; 313-764-3493; Woodrow W. Hunter; 1965 31.

Mental health of the elderly, pre-retirement education, space and behavior of elderly, housing, milieu therapy.

Institute of Growth and Development; University of Nebraska; 42nd Street and Dewey Avenue, Omaha, Nebraska 68105; 402-551-0069; Dr. Robert B. Kugel; 1961 41.

Mental retardation.

Institute of Life Sciences; Brown University; Providence, Rhode Island 02912; 401-863-2277; Dr. Herman B. Chase; 1957 57.

Social and economic aspects of aging.

Institute of Rehabilitation Medicine; New York University; 400 East 34th Street, New York, New York 10016; 212-679-3200; Dr. Howard A. Rusk; 200.

Rehabilitation medicine; employment problems of the deaf.

Institute of Aging; University of South Florida; 4202 Fowler Avenue, Tampa, Florida 33620; 813-974-2409; Dr. Thomas A. Rich; 1967 28.

Gerontology, sociological and public policy aspects.

Lafayette Clinic; Wayne State University; 951 East Lafayette, Detroit, Michigan 48207; 313-963-5400; Dr. Jacques S. Gottlieb; 1955 410.

Interdisciplinary studies of mental retardation.

Medical Rehabilitation Research and Training Center; University of Alabama in Birmingham; 1717 Sixth Avenue, South, Birmingham, Alabama 35233; 205-325-4900; Dr. Edward H. Holmes, Jr.; 250.

Medical, social and vocational rehabilitation.

Medical Rehabilitation Research and Training Center; Emory University; 80 Butler Street, S.E., Atlanta, Georgia 30303; 404-377-4211; Dr. John V. Basmajian; 1965 48.

Medical Rehabilitation Research and Training Center; Tufts University; 171 Harrison Avenue, Boston, Massachusetts 02111; Dr. Carl V. Granger.

Medical Rehabilitation Research and Training Center; Temple University; 3400 North Broad Street, Philadelphia, Pennsylvania 19122; Dr. Richard Herman.

Medical Rehabilitation Research and Training Center; University of Washington; 15th Avenue, N.E., Seattle, Washington 98105; Dr. Justus F. Lehmann.

Medical Rehabilitation Research; University of Minnesota; 860 May Building; Minneapolis, Minnesota 55455; Dr. Frederic Kottke.

Medical Rehabilitation Research and Training Center; University of Wisconsin; 415 West Gilman Street, Madison, Wisconsin 53706; 608-262-4354; Dr. F. Rick Heber; 1963 17.

Professional functions of rehabilitation counselors, their training and organization.

Medical Rehabilitation Research and Training Center; George Washington University; 2150 Pennsylvania Avenue; Washington, D.C. 20037; Dr. John P. Naughton.

Medical Rehabilitation Research and Training Center; University of Colorado; 4200 E. Ninth Avenue, Denver, Colorado 80220; Dr. Jerome W. Gersten.

Mental Retardation Research Center; 1100 West Michigan Street, Indianapolis, Indiana 46202; 317-639-8702; Dr. Arthur L. Drew; 1965 14.

Mental retardation; neurological and genetic aspects, learning disabilities.

Ohio Valley Health Services Foundation; Ohio University; 1 Community Drive, Athens, Ohio 45701; 614-594-7861; Jack E. Farrington; 1966 13.

Community health delivery systems; medical care financing, nursing problems and rural health care.

Ohio Valley Mental Retardation Evaluation Unit; Ohio University; Athens, Ohio 45701; 614-594-2561; Kenneth Sweeney; 1968 10.

Development of case study data on handicapped persons of all ages in rural Appalachia.

Regional Rehabilitation Research Institute; University of Florida; Gainsville, Florida 32601; 904-392-3001; Dr. John E. Muthard; 1962 18.

Vocational rehabilitation and behavioral science; inter-disciplinary studies on personnel and research utilization in rehabilitation professions.

Rehabilitation Center; University of Illinois; 840 South Wood Street, Chicago, Illinois 60680; 312-663-6704; Dr. E. Buso; 1963 16.

Methods of long term care of disabled.

Rehabilitation Institute; University of South Florida; Tampa, Florida 33623; 813-974-2855; Dr. Calvin M. Pinkard; 1970 3.

Rehabilitation counselling.

Rehabilitation Institute; Southern Illinois University; Carbondale, Illinois 62701; Dr. Guy A. Renzaglia; 1957 30.

Placement and rehabilitation of the handicapped, counsellin

Rehabilitation Institute; Wayne State University; Mock Boulevard, Detroit, Michigan 48201; 313-833-4300; Dr. Joseph N. Schaeffer; 1951 286.

Rehabilitation medicine.

Rehabilitation Institute of Chicago; Northwestern University; 401 East Ohio Street, Chicago, Illinois 60611; Dr. Henry B. Betts.

Recently established research unit on the sociological problems of rehabilitation.

Rehabilitation Research Center; College of Education; University of Oregon; 351 Clinical Services Building, Eugene, Oregon 97403; Dr. Andrew S. Halpern.

Regional Rehabilitation Center; University of Washington; Seattle, Washington 98105; 206-543-3600; 1962 65.

Rehabilitation of the physically handicapped.

Research and Training Center; University of Southern California; Room 102, North Hall, 1739 Griffin Avenue, Los Angeles, California 90031; Dr. Lorin L. Stephens.

Research and Training Center in Mental Retardation; Texas Tech University; P.O. Box 4100, Lubbock, Texas 79409; Dr. Gerard J. Bensberg.

Rose F. Kennedy Center for Research in Mental Retardation and Human Development; Yeshiva University; 1410 Pelham Parkway South, Bronx, New York 10461; Dr. Harry H. Gordon; 1967.

Southwest Center for Gerontological Studies; University of Oklahoma; 1700 Asp Avenue, Norman, Oklahoma 73069; 405-325-1731; Helen D. Gavin; 1965 8.

Psycho-social problems of the aged, social perception.

Texas Institute for Rehabilitation and Research; Baylor College of Medicine; 1333 Moursund Avenue, Houstin, Texas 77025; 713-526-4281; Dr. Wm. A. Spencer; 1959 280.

Care of long term chronically ill and physically disabled patients; experimental residential program for young, severely handicapped adults.

Texas Research Institute of Mental Sciences; Baylor College of Medicine; 1300 Moursund Avenue, Houston, Texas 77025; 713-526-4151; Dr. Wm. M. McIsaac; 1961 375.

Biochemical aspects of gerontology.

University Rehabilitation Center; University of Arizona; Second and Vine Streets, Tucson, Arizona 85721; David W. Smith; 1960 80.

Psychological, social, medical and vocational problems of rehabilitation, community organization, educable mental retardates.

Vocational and Rehabilitation Research Institute; University of Calgary; Calgary 44, Alberta, Canada; 403-284-1121; Dr. David Gibson; 1966 63.

Mental retardation, physical disability--social, demographic and biomedical aspects.

Vocational Rehabilitation Research and Training Center; University of Wisconsin-Stout; Menomonie, Wisconsin 54751; Dr. Paul R. Hoffman.

West Virginia Research and Training Center; University of West Virginia; Institute, West Virginia 25112; Dr. Joseph B. Moriarty.

PERIODICALS

AGED

A.A.R.P. News Bulletin; American Association of Retired Persons, 1225 Connecticut Avenue, N.W., Washington, D.C. 20036; $1/monthly.

Adding Life to Years; Institute of Gerontology, University of Iowa, 26 Dyington Road, Iowa City, Iowa 52240; $1/monthly.

Age of Achievement; Elizabeth Hansen, 2516 Monta Vista Place West, Seattle, Washington 98199; $3/monthly/20,000.

Aging (U.S. Dept. of HEW); U.S. Supt. of Documents, Washington, D.C. 20201; $1/monthly/21,000.

Aging and Human Development; Greenwood Periodicals, 51 Riverside Avenue, Westport, Connecticut 06880; $20/quarterly.

Current Literature on Aging; National Council on the Aging, 1828 L Street, N.W., Suite 504, Washington, D.C. 20036; membership/quarterly.

Dynamic Maturity; American Association of Retired Persons, 215 Long Beach Blvd., Long Beach, California 90802; $2/bi-monthly/50,000.

Experimental Gerontology; Pergamon Press, Inc., Maxwell House, Fairview Park, Elmsford, New York 10523; $40/bi-monthly.

Geriatric Institutions; National Geriatrics Society, 10400 Connecticut Avenue, Kensington, Maryland 20795; $5/bi-monthly/21,000.

Geriatric Digest; Geriatrics Digest, Inc., 445 Central Avenue, Northfield, Illinois 60093; $15/monthly/15,000.

Geriatrics; Dr. John F. Briggs, 4015 West 65th Street, Minneapolis, Minnesota 55435; $21/monthly/51,000.

Gerontologia; S. Karger, AG, Boeck Linstr. 25, 4,000 Basel 11, Switzerland; $25/quarterly/650.

Gerontologia Clinica; S. Karger, AG, Boeck Linstr. 25, 4,000 Basel 11, Switzerland; $16.20/bi-monthly/1100.

Gerontologist; Gerontological Society; 1 Dupont Circle, Number 520, Washington, D.C. 20036; $10/quarterly/4200.

Harvest Years; Harvest Years Publishing Co., Inc., 104 East 40th Street, New York, New York 10016; $6/monthly/100,000.

Industrial Gerontology; National Council on the Aging, 1828 L Street, N.W., Washington, D.C. 20036; free/quarterly.

Journal of Gerontology; Gerontological Society, 1 Dupont Circle, Number 520, Washington, D.C. 20036; $26/quarterly/4100.

Journal of American Geriatrics Society; American Geriatrics Society, 10 Columbus Circle, New York, New York 10010; $15/monthly/9420.

Lifespan; Foundation for Aging Research, 50 West 57th Street, New York, New York 10019; $5/quarterly.

Locke Report (Retirement Planning and Living); Edward M. Cooney, 594 Front Street, Marion, Massachusetts 02738; $6/6 per year.

Medicare Report; National Features Syndicate, Inc., 105 2A National Press Building, Washington, D.C. 20004; $48/semi-monthly.

Methodist Homes Quarterly; Methodist Homes of New Jersey, 81 Clark Avenue, Ocean Grove, New Jersey 07756; -/quarterly/11,858.

Modern Maturity; American Association of Retired Persons, 215 Long Beach Blvd., Long Beach, California 90802; membership/bi-monthly/2,000,000.

Modern Nursing Home; McGraw-Hill Publishing Co., 1050 Merchandise Mart, Chicago, Illinois 60654; $12/monthly/21,000.

Nursing Home Administrator; 1050 Merchandise Mart, Chicago, Illinois 60654; $3/bi-monthly.

Nursing Homes; American Nursing Home Association, 1346 Connecticut Avenue, N.W., Washington, D.C. 20006; $10/monthly.

Professional Nursing Home; 2501 Wayzata Blvd., Minneapolis, Minnesota 55440; $5/monthly.

Retired Officer; Retired Officer's Association, 1625 Eye Street, N.W., Washington, D.C. 20006; $3/monthly.

Retirement Life; National Association of Retired Civil Employees, 1909 Que Street, N.W., Washington, D.C. 20009; membership-free/monthly/100,000; nonmembers-$3.

HANDICAPPED

American Annals of the Deaf; Conference of Executives of American Schools for the Deaf, 5034 Wisconsin Avenue, N.W., Washington, D.C. 20002; $5/5 per year/4000.

American Archives of Rehabilitation Therapy; American Association of Rehabilitation Therapy, Inc., Box 93, North Little Rock, Arkansas 72115; members-free/ quarterly/711; nonmembers-$5.

American Journal of Occupational Therapy; American Occupational Therapy Association, 251 Park Avenue, South, New York, New York 10010; members-free; non-members-$10.50; institutions-$12.50/8 per year/12,972.

Annals of Allergy; American College of Allergists, 2642 University Avenue, St. Paul, Minnesota 55114; $12.50/ monthly 3400.

Arthritis and Rheumatism; Harper and Row, 49 East 33rd Street, New York, New York 10016; $18/bi-monthly.

Bulletin of Prosthetics Research; Research and Development Division, Prosthetic and Sensory Aids Service, Veteran's Administration, Supt. of Documents, U.S. Government Printing Office, Washington, D.C. 20402; -/semi-annually/ 5,500.

Journal of Rehabilitation; National Rehabilitation Association, 1522 K Street, N.W., Washington, D.C. 20005; -/bi-monthly/ 35,000.

New Outlook for the Blind; West 16th Street, New York, New York 10011; $6/monthly (except July and August)/4000.

Rehabilitation and Health; National Institutes on Rehabilitation and Health Services, 1714 Massachusetts Avenue, N.W., Washington, D.C. 20036; $10/monthly/5000.

Rehabilitation Counseling Bulletin; American Rehabilitation Counseling Association, 1607 New Hampshire Avenue, Washington, D.C. 20009; $7/quarterly/2355.

Rehabilitation Literature; National Society for Crippled Children and Adults, Inc., 2023 West Ogden Avenue, Chicago, Illinois 60612; $4.50/monthly.

Rehabilitation Record (U.S. Dept. of HEW); Rehabilitation Services Administration, Supt. of Documents, U.S. Government Printing Office, Washington, D.C. 20402; $3/bi-monthly.

Rehabilitation Teacher; National Braille Press, Inc., 88 St. Stephen Street, Boston, Massachusetts 02115; $1.50/monthly/600.

Washington Report; American Foundation for the Blind, 15 West 16th Street, New York, New York 10011; free/bi-monthly/7500.

RETARDED

American Journal of Mental Deficiency; Boyd Printing Co., 49 Sheridan Avenue, Albany, New York 12210; $18/bi-monthly/11,600.

Journal of Mental Deficiency Research; National Society for Mentally Handicapped Children, 86 Newman Street, London W. 1, England; $12/quarterly.

Mental Retardation; Canadian Association for the Mentally Retarded, Kinsmen NIMR Bldg., York University, 4700 Keele Street, Downsview, Ontario, Canada; $1/quarterly.

Mental Retardation News; 2709 Avenue E, East Arlingtin, Texas 76011; $2.50/10 per year/158,000.

P.C.M.R. Message; President's Committee on Mental Retardation, Washington, D.C. 20201; free/6 per year/10,000.

OTHER

A.I.A. Journal; American Institute of Architects, 1735 New York Avenue, N.W., Washington, D.C. 20006; $5/monthly/30,000.

American Corrective Therapy Journal; University of Texas, Sutton Hall, 107, Austin, Texas 78712; $8/bi-monthly/963.

American Journal of Building Design; American Institute of Building Design, 1830 West 8th Street, Los Angeles, California 90057; $5/monthly.

Architectural Forum; Lawrence W. Nester, Whitney Publications, Inc., 130 East 59th Street, New York, New York 10022; $12/monthly.

Architectural Record; McGraw-Hill, Inc., 330 West 42nd Street, New York, New York 10036; $7.50/monthly/52,000.

Building Costs; Boeckh (E.H.) and Associates, 1406 M Street, N.W., Washington, D.C. 20006; -/monthly/$10.

Children (U.S. Dept. of HEW); Office of Child Development; Washington, D.C. 20201; $2/bi-monthly/30,000.

Community Mental Health Journal; Behavioral Publications, Inc., 2852 Broadway, New York, New York 10025; $20/ quarterly/4250.

Construction Review; Supt. of Documents, Washington, D.C. 20402; $6.50/monthly/3000.

Design and Environment; RC Publications, 6400 Goldsboro Rd., N.W., Washington, D.C. 20034; $11/quarterly/10,000.

Environmental Design; Alaska Construction News, Inc., 2916 Western Avenue, Seattle, Washington 98121; $5/bi-monthly/ 11,600.

Exchange Bibliographies; Council of Planning Librarians, P.O. Box 229, Monticello, Illinois 61856.

Health Care Product News; Market Publications, Inc., 125 Elm Street, New Canaan, Connecticut 06840; $12.50/monthly/ 71,000.

Health, Education and Welfare Indicators; Supt. of Documents, Washington, D.C. 20402; $3.50/monthly.

Health Institution Purchasing; Medical Publications, Division of Harcourt-Brace-Jovanovich, Inc., 1603 Orrington Avenue, Suite 1330, Evanston, Illinois 60201; $10/monthly/32,000.

Hospital; Clissold Publishing Co., 401 N. Wabash Avenue, Chicago, Illinois 60611 (text in Spanish); $8/bi-monthly.

Hospital Abstract Service; Physicians' Record Co., 3000 South Ridgeland Avenue, Berwyn, Illinois 60402; $12/monthly/ 4000.

Hospital Administration; American College of Hospital Administrators, 840 North Lake Shore Drive, Chicago, Illinois 60611; $5/quarterly/11,000.

Hospital Affairs in New York State; New York State Dept. of Health, 84 Holland Avenue, Albany, New York 12208; -/quarterly.

Hospital Association of New York State News; New York State Hospital Association, 15 Computer Drive, West, Albany, New York 12205.

Hospital Financial Management; Hospital Financial Management Association, 840 North Lake Shore Drive, Chicago, Illinois 60611; $15/monthly/10,000.

Hospital Handbook; Associated Products Publications, 5430 Van Nuys Blvd., Van Nuys, California 91401; $5/monthly/ 10,097.

Hospital Management; Clissold Publishing Co., Suite 534, 401 N. Wabash, Chicago, Illinois 60611; $15/monthly/38,500.

Hospital Supervision; American Management Association, 135 West 50th Street, New York, New York 10020; free-members, $16 non-members/semi-monthly/6200.

Hospital Supervisor's Bulletin; Bureau of Business Practice, 24 Rope Ferry Rd., Waterford, Connecticut 06385; $15/ semi-monthly.

Hospital Topics; Hospital Topics, Inc., 4747 West Peterson Avenue, Chicago, Illinois 60646; $15/monthly/36,000.

Hospitals; American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611; $10/semi-monthly/ 64,000.

House and Home; Rockefeller Plaza, New York, New York 10020; $6/monthly/115,000.

Housing; Institute of Housing Managers, Victoria House, Southampton Row, London W.C. 1, England; -/bimonthly.

Housing and Planning References; U.S. Dept. of HUD, Supt. of Documents, Washington, D.C. 20402; $3/bi-monthly/2000.

Institutional Building; Bethune Jones, 321 Sunset Avenue, Asbury Park, New Jersey 07712; $26.40/14 per year.

Journal of Health and Social Behavior; American Sociological Association, 1001 Connecticut Avenue, N.W., Washington, D.C. 20036; membership-free, non-members $8, institutions $10/quarterly/2000.

Journal of Housing; National Association of Housing and Redevelopment Officials, 2600 Virginia Avenue, N.W., Washington, D.C. 20037; $8/11 per year/14,000.

Journal of Marriage and the Family; National Council of Family Relations, 1219 University Avenue, S.E., Minneapolis, Minnesota 55414; membership-free/quarterly/7500.

List of Technical Studies and Experimental Housing Projects; U.S. Dept. of Housing and Urban Development, Washington, D.C. 20411; free/semi-annually/1400.

Modern Hospital; 1050 Merchandise Mart, Chicago, Illinois 60654; $12/monthly/32,000.

Mortgage Banker; 111 West Washington Street, Chicago, Illinois 60605; $6/monthly/6802.

New York State Statistical Reporter; New York State Division of the Budget, Office of Statistical Coordination, State Capital, Albany, New York 12224; free/bi-monthly.

Public Health Reports; U.S. Public Health Service, Supt. of Documents, Washington, D.C. 20402; $6.50/monthly/13,000.

Public Welfare; American Public Welfare Association, 1313 East 60th Street, Chicago, Illinois 60637; $8/quarterly/12,000.

Social Security Bulletin; Supt. of Documents, Washington, D.C. 20402; $4/monthly.

Social Service Quarterly; National Council of Social Service, 26 Bedford Square, London W.C. 1, England; -/quarterly/2300.

Social Service Review; University of Chicago Press, 5750 Ellis Avenue, Chicago, Illinois 60637; $8/quarterly/3657.

Social Work; National Association of Social Workers, 2 Park Avenue, New York, New York 10016; $10/4 per year/57,000.

Sociology and Social Research; University of Southern California, Los Angeles, California 90007; $6/quarterly/1850.

U.S. Government Publications, Monthly Catalog; Supt. of Documents, U.S. Government Printing Office, Washington, D.C. 20402; $7/monthly.

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002 Frank, K. D. "Government Support of Nursing Home Care." New England Journal of Medicine, V. 287, September 14, 1972, 538-45.

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005 Kiraldi, Louis. Gerontology; an Annotated Bibliography. Kalamazoo: Western Michigan University Committee on Gerontology, 1970.

→006 Koncelik, Joseph A. Considerate Design and the Aging: Review Article with a Selected and Annotated Bibliography. Monticello, Illinois: Council of Planning Librarians, Exchange Bibliography #253 ($1.50), January 1972.

007 Lee, Donald H. A Selected, Annotated Bibliography on Aging and the Aged: 1968-1972. Monticello, Illinois: Council of Planning Librarians, Exchange Bibliography #319 ($4.50), September 1972.

→008 Moore, Julie L., et al. "A Bibliography of Doctoral Dissertations on Aging from the American Institute of Higher Learning, 1934-1969." Journal of Gerontology, V. 26, July 1971, 391-422.

009 National Council on the Aging. Directory of National Organizations with Programs in the Field of Aging. Washington, 1971.

010 National Housing Center Library. Nursing Homes, a Selected List of References, 1964-1969. Washington, D.C.: National Association of Home Builders, 1969.

011 New York State Board of Social Welfare. Master List: Private Proprietary Homes for Adults, Area #2. Rochester, New York, 1971.

012 Shanas, Ethel. "A Coordinated and Supplementary Bibliography on the Sociology of the Elderly." Sociological Symposium, V. 2, Spring 1969. Supplement, 179-221.

*013 Snyder, Lorraine Hiatt. The Environmental Challenge and the Aging Individual. Monticello, Illinois: Council of Planning Librarians, Exchange Bibliography #254 ($4.00), January 1972.

*014 Steidl, Rose E. and Linda M. Nelson. The Ergonomics of Environmental Design and Activity Management for the Aging. Monticello, Illinois: Council of Planning Librarians, Exchange Bibliography #255 ($7.50), January 1972.

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016 _____, Public Health Service, National Institute of Health, National Library of Medicine. Attitudes toward Death, January 1968-March 1971. Washington, D.C.: U.S. Government Printing Office (295 Citations) N.L.M. 71-4, 1971.

→017 _____, _____, National Institute of Health, National Library of Medicine. Day Care for the Elderly, January 1969-November 1972. Washington, D.C.: U. S. Government Printing Office (49 Citations) N.L.M. 73-2, 1973.

018 _____, Social and Rehabilitation Service. The First Six Years of Medicaid - a Selected Annotated Bibliography. Washington, D.C.: U.S. Government Printing Office S.RS. 72-24981, July 1972.

→019 U. S. Department of Housing and Urban Development. The Built Environment for the Elderly and the Handicapped - a Bibliography. Washington, D.C.: U. S. Government Printing Office, 1968.

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023 American Association of Homes for the Aging. The Home Administrator and His Working Relations: Directions. Selection from 6th Annual Conference, ($3.00), 1968.

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025 American Hospital Association. Developing Policies and Procedures for Long Term Care Institutions. Chicago, 1968.

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027 American Public Welfare Association: Public Welfare Project on Aging. Developing Services for Older People. Chicago 1967.

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032 Barker, Michael B. California Retirement Communities. Special Report #2, Center for Real Estate and Urban Economics Institute of Urban and Regional Development. Berkeley: University of California, 1966.

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